



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 15139		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>DONNA</u> MIDDLE <u>B.</u> LAST <u>AARONIAN</u>				2a. DATE OF DEATH MONTH <u>6</u> DAY <u>2</u> YEAR <u>79</u>		2b. HOUR <u>1:28</u> P.M.			
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>Sept.</u> DAY <u>9</u> YEAR <u>1920</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>7605 Carter Court</u>	
14. FATHER'S NAME FIRST <u>Harry</u> MIDDLE <u></u> LAST <u>Silver</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Laura</u> MIDDLE <u></u> LAST <u>(Unknown)</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT ADDRESS <u>Dr. Albert J. Aaronian, Husband. same as item 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac standstill</u> 4234 DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIOMYOPATHY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u> <u>1-3 DAYS</u> <u>1-3 DAYS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-1</u> , 19 <u>79</u> , to <u>6-2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-2</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas G. Sinderen, MD</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6-2-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>THOMAS G. SINDEREN</u>				22e. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE MD. 20852</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>6/5/1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Maryland.</u>			
24. FUNERAL DIRECTOR NAME <u>JOSEPH CAWLER'S SONS INC.</u>				ADDRESS <u>5130 WISC. AVE., N. W. WASH., D. C. 20016</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 8 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Hilary McCready</u>	



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FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15140	
1. DECEASED NAME (TYPE OR PRINT) Bruce Elizabeth Adams										2a. DATE KNOWN OF DEATH ESTIMATED June 5 1979										2b. HOUR 1:00 PM	
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH Aug DAY 29 YEAR 50		6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 		2c. DATE PRONOUNCED DEAD June 5 1979		2d. HOUR 4 PM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Bunker Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse				12b. KIND OF BUSINESS OR INDUSTRY Medical									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE MD		13b. COUNTY Montg		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Bunker Ct.													
14. FATHER'S NAME FIRST Bernard MIDDLE LAST Herrell					15. MOTHER'S MAIDEN NAME FIRST Blance MIDDLE I. LAST Roberts																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 579-40-3514		17. INFORMANT ADDRESS Wm. Adams 503 N. Roosevelt Blvd. Falls Church, Virginia															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide 9520 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 6:15 MONTH 6 DAY 5 YEAR 1979 P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car running in garage													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET Bunker Ct. CITY OR TOWN Rockville COUNTY Mont. STATE MD													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE John P. [Signature]				TITLE (SPECIFY) M.D. [Signature]				MEDICAL EXAMINER				DATE SIGNED June 5 1979									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/9/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery				23d. LOCATION CITY OR TOWN Winchester COUNTY Virginia STATE 											
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR JUN 12 1979				25b. REGISTRAR'S SIGNATURE [Signature]													



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USA

Virginia

2 Banker Court

Waco

Medical

Bernard

Hertel

Blanco

I.

Robert

579-40-3514

to

Mr. Adams 505 N. Woodbury Blvd.
Yelba Church, Virginia

1951 Knoxville, Tenn. 37912
Tyrone Woodson Funeral Home, Inc.
6/25/72 Mt. Vernon Cemetery
Winchester, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		9 15141					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry ELMER X Adams			2a. DATE OF DEATH MONTH DAY YEAR 6-12-79			2b. HOUR 3:00 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEAT CUTTER		12b. KIND OF BUSINESS OR INDUSTRY SAFEGWAY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12004 ASHLEY DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST AMBROSE ADAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTIN WEBSTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-09-7156		17. INFORMANT AUDREY A. HIGDON		ADDRESS SAME AS 13		18. DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Insufficiency 5939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular Disease and Prostatism DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) For dependent Aortic, Chronic Pulmonary Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 8, 1979 to June 12, 1979 , that (I) (we) last saw the deceased alive on June 12, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A Fitzgerald M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-12-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A FITZGERALD				22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.		23e. 25700	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Fitzgerald			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR			7 9 1 5 1 4 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Anna NMN Adler			2a. DATE OF DEATH MONTH DAY YEAR 6 6 79			2b. HOUR 2:05 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 27, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8500 16th Street, Apt. 402	
14. FATHER'S NAME FIRST MIDDLE LAST ELI L. COHEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BECKIE FERDINAND							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 072-01-6488D		17. INFORMANT ADDRESS JEAN E. COHEN, SISTER 1220 EASY WEST HWY. APT. 704, S.S. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis C. V. Disease Long Duration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 Hour</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 10, 1979</u> to <u>5/21, 1979</u> , that (I) (we) lost saw the deceased alive on <u>5/21, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (do) view the body after death.										
22b. SIGNATURE <u>Benjamin Isaacson, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/6/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Isaacson MD						22e. ADDRESS 7733 Alaska Ave. N.W. Wash. D.C. 20012				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/8/1979		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADLEPHI PR. GEO. MD.			
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL						25. DATE JUN 11 1979		26. REGISTERED SIGNATURE <u>Donald M. Stein</u>		
232 CARROLL STREET, N. W., WASHINGTON, D.C.										

cleared with medical examiner 6/6/79 2:15 PM (B.S.)

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herman R Allan			2a. DATE OF DEATH MONTH DAY YEAR 06 28 79		2b. HOUR MIN. 1:05AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 24 13		6. AGE (IN YEARS LAST BIRTHDAY) YRS 66		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDITOR		12b. KIND OF BUSINESS OR INDUSTRY Govt.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8700 Shouffer School Road	
14. FATHER'S NAME FIRST MIDDLE LAST Leroy C. Allen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elise Rettinghouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 268-07-1102		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Adenocarcinoma lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Apr 79 to June 28 1979 , that (I) met lost saw the deceased alive on 6-27-1979 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Jack Schumacher M.D. 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jack Schumacher						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-28-79		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 6/28/79		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board					ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

0 4 1 2 1 4 5

1979: 1 37 45 60

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15144			
1. DECEASED NAME (TYPE OR PRINT) <i>Hennz Amselem</i>										2a. DATE KNOWN OF DEATH EST. MATED <i>June 19, 1979</i>										2b. HOUR OF DEATH <i>1:30 PM</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1888 90</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>90 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <i>June 19, 1979</i>				7d. HOUR OF DEATH <i>1:30 PM</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Morocco</i>				7b. CITIZEN OF WHAT COUNTRY? <i>France</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.											
10. CITY OR TOWN OF DEATH <i>Sit. Spg.</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>8921 2nd Ave</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>											
13a. STATE <i>MD</i>				13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Sit. Spg.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>8921 2nd Ave</i>													
14. FATHER'S NAME FIRST MIDDLE LAST <i>JACOB</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MAZALTOV</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>No</i>				17. INFORMANT ADDRESS <i>Jacques Amselem - 8921 - 2nd Ave, S.S.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <i>429</i> (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>429</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yr.</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>																							
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>John Rogers</i>										TITLE (SPECIFY) <i>MD. Dep.</i>				MEDICAL EXAMINER				DATE SIGNED <i>June 19, 1979</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>John Rogers</i>										ADDRESS <i>1919 Seminary Rd, S.S. 20910</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>6-20-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grangeview Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Belleville Md</i>													
24. FUNERAL DIRECTOR NAME <i>W.W. Chambers</i> ADDRESS <i>8655 Sowa Ave, S.S. Md</i>										25a. DATE REC'D. BY REGISTRAR <i>JUN 28 1979</i>				25b. REGISTRAR'S SIGNATURE <i>Hickory McCreedy</i>									

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7

9

15145

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) George A. Arnold - Jr			2a DATE OF DEATH MONTH DAY YEAR June 2, 1979			2b HOUR 7A M					
3 SEX MALE		4 RACE CAUCASION		5 DATE OF BIRTH MONTH DAY YEAR 04 06 16		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS) MARKETING RESEARCH-RADIO			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE MARYLAND		13b COUNTY MONT.		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1001 SPRING ST. 20910			
14 FATHER'S NAME FIRST MIDDLE LAST G. A. ARNOLD						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LYNCH					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b SOCIAL SECURITY NO. W.W.T.-V.N. 484-09-6441		17 INFORMANT JANICE J. ARNOLD				ADDRESS SAME AS ITEMS H 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 2 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 11 19 77 to 6/2 19 79 , that (I) (we) last saw the deceased alive on 6/1 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE G. Arnold Good, M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 6/2/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 6/6/79		23c NAME OF CEMETERY OR CREMATORY AMES MUNICIPAL			23d LOCATION CITY OR TOWN COUNTY STATE AMES - STORY - TOWN			
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS JR.						ADDRESS SILVER SPRING MARYLAND			25a DATE OF REGISTRATION JUN 11 1979		

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BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, CASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15146	
1. FOR STATE REGISTRAR										7. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edgar J. Arnstine										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5/3 1979	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Dec. 10, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 5/3 1979	
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		2d. HOUR 9:30 P. M.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DeSota Manager										12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. STATE Pa.										13b. CITY OR TOWN Pottstown	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET ADDRESS Briar Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Striker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. WW I 282-10-4732					17. INFORMANT 4016 Chase Avenue James D. Spear, Bethesda, MD 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 5900 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) chronic pyelonephritis. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fracture of right hip.											
19a. DATE OF OPERATION 1/3/79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of right hip.						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1/2 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell out of bed			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing home				21f. LOCATION CITY OR TOWN COUNTY STATE Jones Mill Road, Chevy Chase, Montgomery, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 5/4/79			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-6-79		23c. NAME OF CEMETERY OR CREMATORY Congregation Mercy and Truth Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Pottstown, Pennsylvania	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P. A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 11 1979					

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
MAY 11 1964
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

[Extremely faint and mostly illegible text block containing several paragraphs of a memorandum. Some words like "UNITED STATES", "FEDERAL BUREAU OF INVESTIGATION", and "WASHINGTON, D. C." are faintly visible.]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

15147

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Aseel R Bancroft			2a. DATE OF DEATH MONTH DAY YEAR 6-21-79		2b. HOUR 9 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 22 - 1916	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Monte's MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md	13b. COUNTY Mont	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14804 Sugarlane	
14. FATHER'S NAME FIRST MIDDLE LAST Frank BANCROFT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Pugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Mrs Orlan Bancroft, Poolesville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cut off carcinoma of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF <u>with lymph node,</u> Conditions, if any, which <u>plumal & liver metastases</u> gave rise to immediate <u>cause (a), stating the</u> underlying cause last. (b) _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 max
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22</u> 19 <u>79</u> , to <u>6/21</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B. N. ROSENDAUM</u>		DEGREE		22c. DATE SIGNED 6/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENDAUM		22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 6/23/79	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md	23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JUN 28 1979 <u>Anthony McNeely</u>	
24. FUNERAL DIRECTOR NAME W. L. Graham		ADDRESS 8655 Saw, Ave. S.S.			

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Handwritten text, mostly illegible due to fading. Some words like "Trend" and "mail" are visible.

Vertical handwritten text on the right side of the page.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 5 1 4 8	
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <u>Lester P. Banks</u>					2a. DATE OF DEATH MONTH <u>June</u> DAY <u>12</u> YEAR <u>1979</u>			2b. HOUR <u>1250</u> M			
3. SEX <u>Female</u>		4. RACE <u>Black</u>		5. DATE OF BIRTH MONTH <u>4</u> DAY <u>30</u> YEAR <u>1979</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>60</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Teacher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <u>Maryland</u>		13b. COUNTY <u>MONT</u>		13c. CITY OR TOWN <u>Silver Spr.</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>Silver Spring, 9727 Mt. Pisgah Rd. Md.</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>W.</u> LAST <u>Pyles</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Beatrice</u> MIDDLE <u></u> LAST <u>Hooper</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>219-07-5637</u>		17. INFORMANT ADDRESS <u>Silver Spring, Md. Mr. Walter H. Banks 9727 Mt. Pisgah Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
1539 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Colon</u>										7 mos.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <u></u> A.M. MONTH <u></u> DAY <u></u> YEAR <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 1978</u> to <u>6/12</u> 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>6/12</u> 19 <u>79</u> , and that in (my) <u></u> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>G. L. Nutter</u>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>June 16, 79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>			23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>County Md.</u> STATE <u></u>			
24. FUNERAL DIRECTOR <u>Herbert E. Nutter 3035 W. North Ave.</u>					25. DATE REG'D. BY REGISTRAR <u>JUN 19 1979</u>			26. SIGNATURE <u></u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 15149			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Virginia C. Boringen				2a DATE OF DEATH MONTH DAY YEAR 6 21 79			
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 8 2 94		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY NONE	
13a STATE PENNSYLVANIA				13b COUNTY ALLEGHENY		13c CITY OR TOWN PITTSBURGH	
14 FATHER'S NAME THOMAS				15 MOTHER'S MAIDEN NAME JOSIE CARRELL			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 165-40-1662		17 INFORMANT ADDRESS MARIAN C. WHELAN 119 FOREST AVE., ROCKVILLE, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma in the liver, primary undet.</u> 1552 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (his hospital) attended the deceased from 6/21/79 to 6/21/79, that (he (we)) lost saw the deceased alive on 6/21/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (three) (did) (did not) survive the body after death.							
22b SIGNATURE Robert C. Macon M.D.				22c DATE SIGNED 6/21/79		22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. Macon, M.D.				22f ADDRESS 809 VIERS MILL RD., ROCKVILLE, MD.			
23a BURIAL, CREMATION, REMOVAL BURIAL		23b DATE 6-25-79		23c NAME OF CEMETERY OR CREMATORY ALLEGHENY CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE PITTSBURGH ALLEGHENY PA.	
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE JUN 27 1979 [Signature]	

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Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURENCE L. BARR			2a. DATE OF DEATH MONTH DAY YEAR 6 14 79		2b. HOUR MIN 11:15 A						
3 SEX M		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 29 20		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 11 15		7b. IF UNDER 24 HRS HOURS MIN 11 15	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Health Care Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Craftsman		12b. KIND OF BUSINESS OR INDUSTRY AT&T			
13a. STATE Md.						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Thomas Barr						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth E. Edwards					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Elizabeth P. Barr		18. ADDRESS 8605 Springvale Road Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: 1619 IMMEDIATE CAUSE (a) Carcinoma of Larynx DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Chronic DUE TO, OR AS A CONSEQUENCE OF (c) Chronic											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:30 P.M. 6/19 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4115 Colie Dr. Wheaton			
22a. I certify that (I) (this hospital) attended the deceased from 6/14 79 to 6/19 79 that (I) (we) last saw the deceased alive on 6/14 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
22b. SIGNATURE R. T. Benack				22c. DEGREE MD				22d. DATE SIGNED 6/14/79		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. Benack				23b. ADDRESS 4115 Colie Dr. Wheaton							
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23d. DATE June 16, 79		23e. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23f. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg. Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home						24b. ADDRESS 11800 New Hampshire Ave. S. S. Md. 20904		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		7 15151					
1. DECEASED NAME (TYPE OR PRINT) HAZEL E. BATCHELDER				2a. DATE OF DEATH MONTH DAY YEAR June 30 1979		2b. HOUR 10 45 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kullman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 285 03 4143		17. INFORMANT 308 Burnt Mills Ave. S.S. Md. Robert Batchelder (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accidents 436- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DD Degenerative Arthritis (2) Cholelithiasis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 6/30 19 79, that (I) (we) last saw the deceased alive on 6/27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alan R. Gair MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. Gair MD				22e. ADDRESS 11700 Old Columbia Pike Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/6/79		23c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Medima, Ohio			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUL 5 1979		25b. REGISTRAR'S SIGNATURE R. Hines	

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Released by Mr. Mayle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR					79 15152 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Opal Lucille Bayles					7a. DATE OF DEATH MONTH DAY YEAR 06 24 79					7b. HOUR 10 ²² AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19 1929			6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7c. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Poolesville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21101 Westerly Road					
14. FATHER'S NAME FIRST MIDDLE LAST Walter R. Tiller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Ball							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 577-32-9062		17. INFORMANT ADDRESS Pat Tigner Gaithersburg, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY.) IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION 2500 } DUE TO, OR AS A CONSEQUENCE OF CORONARY HEART DISEASE (b) } DUE TO, OR AS A CONSEQUENCE OF DIABETES MELLITUS (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours 1 year 10 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 6-24-79 to 6-24-79, that (1) (we) lost saw the deceased alive on 6-24-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE Robert J. Linderman					DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 6-24-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Linderman					22e. ADDRESS Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE June 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Laytonsville			23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.		
24. FUNERAL DIRECTOR NAME Francis H. Barber					ADDRESS Laytonsville, Maryland			25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 weeks of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be completed by a coroner.

BP _____

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY J BEAN			2a. DATE OF DEATH MONTH DAY YEAR June 27 1979 6:45 P.M.		
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 4 - 14 - 1979	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ass't to Chief of Budget		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Ag.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY Washington 13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Worthington R. Bean			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Pugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-54-5472	17. INFORMANT ADDRESS Thomas M. Raysor 5530-Wisc. Ave. N.W. Washington, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY Failure DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA Colon & Metastasis To DUE TO, OR AS A CONSEQUENCE OF Left Kidney, LUNGS, PANCREAS (c) Liver					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION MARCH 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY , 19 77 , to 6/27 , 19 79 , that (I) (we) last saw the deceased alive on 6/21 , 19 79 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Albert E. Marland, Jr.		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert E. MARLAND JR.		22e. ADDRESS 2737 Devonshire Place, DE 20008			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/30/1979		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Norristown Penna.		24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. Inc. 11800-N.H. Ave. Sili. Spg. Md.			
25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15154

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6 23 79		7 ¹⁵ PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		CAUCASIAN		MONTH DAY YEAR 1 30 92		87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		USA		MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Wheaton		Randolph Hills Nursing Home		Buyer		Garfinckel Retail	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
James J. Smith		Alice Buffin				577 03 5988	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS METASTATIC</u>		19. ADDRESS		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Betty Peifer		1579		2505 Urbana Drive Silver Spring, Maryland		7 YEAR	
21. INJURY OCCURRED		22. SIGNATURE		23. DATE		24. FUNERAL DIRECTOR	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		MARTIN C SHARGEL		6/26/79		Robert A. Pumphrey Funeral Homes, PA Bethesda, Maryland	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED	
JUN 27 1979		Dorothy McCreedy					

MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 9/26 1978, to 6/23 1979, that (1) (we) lost the deceased after on 6/20 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		MARTIN C SHARGEL				6/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
MARTIN C SHARGEL		3720 FARRAGUT AVE KENSINGTON MD-20795		Burial		6/26/79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Cedar Hill Cemetery		Suitland, Maryland		Robert A. Pumphrey Funeral Homes, PA Bethesda, Maryland		JUN 27 1979	

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1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments and is intended to give a detailed impression of the work done during the year.

3. The third part of the report is a statement of the work done by each of the individuals in each of the departments. It is a summary of the work done by each of the individuals and is intended to give a detailed impression of the work done during the year.

4. The fourth part of the report is a statement of the work done by each of the committees in each of the departments. It is a summary of the work done by each of the committees and is intended to give a detailed impression of the work done during the year.

5. The fifth part of the report is a statement of the work done by each of the sub-committees in each of the departments. It is a summary of the work done by each of the sub-committees and is intended to give a detailed impression of the work done during the year.

6. The sixth part of the report is a statement of the work done by each of the individuals in each of the sub-committees. It is a summary of the work done by each of the individuals and is intended to give a detailed impression of the work done during the year.

7. The seventh part of the report is a statement of the work done by each of the committees in each of the sub-committees. It is a summary of the work done by each of the committees and is intended to give a detailed impression of the work done during the year.

8. The eighth part of the report is a statement of the work done by each of the sub-committees in each of the sub-committees. It is a summary of the work done by each of the sub-committees and is intended to give a detailed impression of the work done during the year.

9. The ninth part of the report is a statement of the work done by each of the individuals in each of the sub-committees. It is a summary of the work done by each of the individuals and is intended to give a detailed impression of the work done during the year.

10. The tenth part of the report is a statement of the work done by each of the committees in each of the sub-committees. It is a summary of the work done by each of the committees and is intended to give a detailed impression of the work done during the year.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 1 5 1 5 5	
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Dora A. Behrens						June 7, 1979			8 P.M.		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Aug. 14, 1899		79 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Ill.		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Chevy Chase Nursing Center				Homemaker		Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2216 Washington Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Christian Theurer				Mary Wintler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				220-54-0454		Mrs. Joan O'Connell 9635 Culver St. Kensington, Md. 20795					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 3498 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Degenerative Neurologic Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9 - 19 78</u> to <u>5-30</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5-30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Christopher Unger MD.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-7-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher U. Unger						22e. ADDRESS 8218 Wisconsin Ave. #208 Bethesda, Maryland 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			June 9, 1979		Ft. Lincoln Cemetery		Brentwood, Md.				
24 FUNERAL DIRECTOR JOSEPH CAWLER'S SONS INC. NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR JUN 13 1979 REGISTRAR'S SIGNATURE H. J. McCreedy					
5130 WISG. AVE., N. W. WASH., D. C. 20018											

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 1 5 6		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Andrew Joseph Beitzell				2a. DATE OF DEATH MONTH DAY YEAR June 6, 1979		2b. HOUR 5:15 P _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Radio Technician		12b. KIND OF BUSINESS OR INDUSTRY Communication	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia				13b. COUNTY Fairfax		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 7607 Hogarth Street 22151				14. FATHER'S NAME FIRST MIDDLE LAST Andrew W Beitzell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois J Olson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT The Medical Record The Clinical Center, NIH, Beth., Md					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1869 IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Embryonal carcinoma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 May 1979 to 6 June 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 6 June 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Byron D. McLees M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. CITY OR TOWN'S NAME (TYPE OR PRINT) BYRON D. McLees				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 9, 1979		23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Pk		23d. LOCATION Fairfax		23e. COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Demaive Wj Suley		ADDRESS 520 S. Wash. St Alex. VA		DATE REC'D. BY REGISTRAR JUN 15 1979		25. REGISTRAR'S SIGNATURE Morty McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK J BERCHTOLD			2a. DATE OF DEATH MONTH DAY YEAR 6-27-79			2b. HOUR 12:32 A.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 MAY 1883		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SWITZERLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Gov't		12b. KIND OF BUSINESS OR INDUSTRY Mech.	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 1177 E. 1st St.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. SIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4636 - 4th St.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Berchtold				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thersa Britsghi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 557-50-3865		17. INFORMANT DAUGHTER				ADDRESS MRS. LOUISE WALKER ADDRESS AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION CEREBRUM, LEFT 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CEREBRAL THROMBOSIS, LEFT (c) CEREBRAL ARTERIO SCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 3 WEEKS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) GENERAL ARTERIO SCLEROSIS MI, ACUTE INFECT, RECENT									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from APRIL 12, 1978 , to JUNE 27, 1979 , that (2) (we) last saw the deceased alive on JUNE 27, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) did (did not) view the body after death.									
22b. SIGNATURE James A. Roberts				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. ROBERTS				22e. ADDRESS 8907 GEORGIA AVE. SILVER SPRING, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2-27-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR Warner E. Pumphrey Inc.				ADDRESS 8434 Wisconsin Silver Spring Md.		25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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[Faint handwritten signature or mark]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 5 1 5 8 REG. NO. 490228					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE ELDER BERRY					2a. DATE OF DEATH MONTH DAY YEAR JUNE 05, 1979			2b. HOUR 9:24A _M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR FEB. 01 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY N/A		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN R. ELDER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE STEPHENSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS ELMER BERRY (HUSBAND) SAME AS ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RIGHT CEREBRO-VASCULAR ACCIDENT</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <u>05 APRIL</u> , 19 <u>79</u> , to <u>05 JUNE</u> , 19 <u>79</u> , that (we) lost saw the deceased alive on <u>05 June</u> , 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael W. Meriwether MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6 June 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL MERIWETHER					22e. ADDRESS NNMC BETHESDA, MD 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6-7-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Va.			
24. FUNERAL DIRECTOR Robert A. Pumphrey FUNERAL HOME, P.A., BETHESDA, MD.					25a. DATE REC'D. BY REGISTRAR JUN 14 1970		25b. REGISTRAR'S SIGNATURE Patricia A. Bandy			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 1 5 1 5 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST ADA	MIDDLE P.	LAST BILLS	2a. DATE OF DEATH MONTH DAY YEAR 6/25/79
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 72
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOBOR SAN HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST John Phillips		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hassam		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dancer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 52 7208		17. INFORMANT ADDRESS Carol Ann Deakin 4914 Greenway Drive Bethesda Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - heart</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral - vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 min 48 hrs 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1 May 1979</u> to <u>25 June 1979</u> , that (I) (we) last saw the deceased alive on <u>25 June 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u> MD 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES M. WYMAN M.D.				22c. DATE SIGNED 6/25/79	
22e. ADDRESS 7801 MARSHALL AVE Bethesda, MD				22f. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/28/79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, PA BETHESDA MARYLAND		23d. LOCATION CITY OR TOWN Bethesda, MD			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 15160			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Rath		MIDDLE V.		LAST BIVINS		2a. DATE OF DEATH		MONTH 6	DAY 24	YEAR 79	2b. HOUR 8:15 P.M.
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Apr. 30, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE ALA		13b. COUNTY DALE		13c. CITY OR TOWN OZARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route #1 - Box 411					
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR Wigham		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 418-34-0428		17. INFORMANT ADDRESS Joyce Watson - 4803 Artic Court Rockville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal bleeding</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 5 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Renal Failure Hepatic Failure</u>													
19a. DATE OF OPERATION 6/22/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastrointestinal hemorrhage				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 6/22, 19 79, to 6/24, 19 79, that (1) (we) last saw the deceased alive on 6/24, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.													
22b. SIGNATURE Robert H. Varney, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/25/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H. Varney, MD.		22e. ADDRESS 5411 Cedar Lane, Bethesda, Md 20014											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6-26-79		23c. NAME OF CEMETERY OR CREMATORY OZARK FUNERAL HOME				23d. LOCATION CITY OR TOWN COUNTY STATE DALE ALA.					
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Washington St. Rockville, Md. 20858		25a. DATE REC'D BY REGISTRAR JUN 26 1979									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medic examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DORIS SEIDEL BLACKBURN			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1979			2b. HOUR 8:30 A.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 50		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1803 McAuliffe Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Rockville		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1803 McAuliffe Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank - Seidel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Wolf					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-40-2460		17. INFORMANT ADDRESS William J. Blackburn Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1919 BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (b) (GLIOMA) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 4.4.78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19 to 1979, that (I) (we) lost saw the deceased alive on 2.9.79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Snow MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-12-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Margaret T. Snow, MD.				22e. ADDRESS 9013 Flower Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 14, 1979		23c. NAME OF CEMETERY OR CREMATORY Friends Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Mont. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20760				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 15162		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
SR. MARY BERNARD		BLANCANEUX		6 20 79		10 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		JAN. 28, 1908		71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
SOUTH AMERICA		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		TEACHER		Religious	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Potomac			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
FRANCIS		EMELIE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1000 KENTSDALE DRIVE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		037-420235		SR Doris GOTTEMORIE		SAME #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7302		Septicemia		Cervical osteomyelitis		3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		1 month	
				Bilateral pneumonia		24 hours	
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
Cervical myelopathy due to osteomyelitis, spine							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
6/15/79		Cervical osteomyelitis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		6/20 19 79		to 6/20 19 79		that (I) (we) lost	
saw the deceased alive on		6/20 19 79		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
above, that (we) did (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
John T. Lord		M.D.		7910 Woodmont Ave		6/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
John T. Lord		Suite 1100, Bethesda Md.		BURIAL		6-25-79	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
RESURRECTION CEM		CUMBERLAND		JUN 26 1979		R. J. [Signature]	
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Frank D. [Signature]		WASH. DC		JUN 26 1979		[Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15163

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROCKWARD NUSBAUM BLANDY						2a. DATE KNOWN OF DEATH June 14 1979		2b. HOUR OF DEATH 11:39 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 31 1960	6. AGE (IN YEARS) 18 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD June 14 1979		2d. HOUR OF DEATH 11:39 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mount General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trailer Park		12b. KIND OF BUSINESS OR INDUSTRY Operator	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Damascus		13d. STREET ADDRESS 2518 Woodfield Rd			
14. FATHER'S NAME FIRST Rockward MIDDLE Abram LAST Nusbaum				15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE A. LAST Starr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes - World War II		16b. SOCIAL SECURITY NO. 579-07-9797		17. INFORMANT Mrs. Helen A. Haddox, Damascus, Md.				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) Dep		MEDICAL EXAMINER				DATE SIGNED June 15 1979	
EXAMINER'S NAME (TYPE OR PRINT) John Rogers, M.D.		ADDRESS Montgomery County Gen. Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/18/1979		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION CITY OR TOWN Rockville, Maryland			
24. FUNERAL DIRECTOR NAME W. D. Shultz		ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Richard M. Brady			

1 2 1 0 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

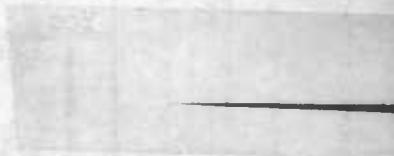
DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR 1 - STATE REGISTRAR		7 9 1 5 1 6 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
David ----- Bornet		MONTH DAY YEAR HOUR 6 - 20 - 79 8:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	Caucasian	MONTH DAY YEAR April 7, 1892	87 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
New York	USA		Montgomery MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Carriage Hill Nursing Home	Retired Banker	Bank
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
13a. STATE Maryland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9101 Second Avenue
13b. COUNTY Montgomery			
13c. CITY OR TOWN Silver Spring			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard ----- Bornet		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine ----- (Unknown)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes <input checked="" type="checkbox"/> WWI		578-05-2416	
17. INFORMANT		ADDRESS	
Jack Rubin		D. C. 4501 Conn. Ave. NW, Washington,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Ascending Urinary Tract Infection</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/18</u> 19 <u>79</u> , to <u>5/26</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Marvin Fuchs</u>		DEGREE MD	22c. DATE SIGNED 6-20-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Fuchs, M. D.		22e. ADDRESS 5315 Conn. Ave., N. W., Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	6-22-79	Washington Hebrew	Washington, D. C.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Danzansky-Goldberg Mem. Chap. Rockville, Md.		1170 Rockville Pk. ADDRESS	JUN 25 1979 <u>Robert McCreedy</u>

1 2 1 0 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 342.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR			REG. NO. 9 15165											
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR		
Archie T. Broadhurst			6-13-79		12P									
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		Cauc.		Nov 1 1908		70 YRS.		MONTHS		DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.				Montgomery						MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda		Suburban Hospital		Bookkeeper		Accounting								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
				MD		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4863 Battery Lane (apt. #2)		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST				FIRST MIDDLE LAST										
Samuel V. Broadhurst				Caroline Watkins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No				577-01-9792		Lillian H. Broadhurst (Same as 13e)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) CEREBRAL ANOXIA										2 DAYS				
DUE TO, OR AS A CONSEQUENCE OF (b) 496 - SUPPNEUMONECTOMY										REMOTE				
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE PULM DES. AND CHF										YRS 26 DAYS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
CARINOMA OF LUNG														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 19 63, to June 13 79, that (I) (we) last saw the deceased alive on June 13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
George Mitchell								6/14/79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
			11125 Rockville Pike, Rockville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL			6-16-79		Ft. Lincoln Cem.		Suitland		5		Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.						JUN 19 1979		H. J. McCreedy						

BP

12102



Handwritten notes and stamps, including a large circular stamp with a cross in the center.

Handwritten notes and stamps, including a large circular stamp with a cross in the center.

Handwritten notes and stamps, including a large circular stamp with a cross in the center.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15166

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. FIRST		3. MIDDLE		4. LAST		5. DATE OF BIRTH		6. MONTH	
Blanche		L.		Brown				6/3/1979		8:22 PM	
7. SEX		8. RACE		9. DATE OF BIRTH		10. AGE (IN YEARS)		11. IF UNDER 1 YR.		12. IF UNDER 24 HRS.	
Female		White		2 11 15		64 YRS.					
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14. CITIZEN OF WHAT COUNTRY?		15. MARRIED		16. NEVER MARRIED		17. BALTIMORE CITY OR COUNTY OF DEATH		18. MD.	
North Carolina		U.S.A.		WIDOWED		DIVORCED		Montgomery County			
19. CITY OR TOWN OF DEATH		20. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		22. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Homemaker		Home					
19a. STATE		19b. COUNTY		19c. CITY OR TOWN		19d. INSIDE CITY LIMITS?		19e. STREET ADDRESS			
MD		MONTGOMERY		BETHESDA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6200 WAGNER LANE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS							
M. R. Lee		Mary Lou Lee		Woody							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS					
No		NOT AVAILABLE		Albert L. Brown		(Same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY:		ACUTE									
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS		DEF.									
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) CORONARY ARTERIOSCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		6:30 P.M. 6 3 19 79		CHEST PAIN AT HOME							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		Home		6200 WAGNER LANE BETHESDA MONT. MD							
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		6/4/79	
ACTUAL SIGNATURE		F. C. MAYHE		M.D.							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		8200 Wisconsin Ave Bethesda MD 20814							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		6-7-79		Cedar Hill Cem.		Suitland		Md.			
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.						JUN 12 1979		Anthony McCready			

15100



Family Name: [illegible]
Birth Date: [illegible]
Birth Place: [illegible]
Married Name: [illegible]
Married Date: [illegible]
Married Place: [illegible]
Occupation: [illegible]
Address: [illegible]
Phone: [illegible]
Religion: [illegible]
Education: [illegible]
Service: [illegible]

[Faint, mostly illegible text, possibly a continuation of the form or a separate document. Includes some handwritten notes and signatures.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 15167

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah J. Brown			June 12, 1979			5:00a_M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR AUG. 30 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 72		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Derwood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7101 Panorama Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DERWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7101 PANORAMA DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST CARY BROWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 084-07-6587		17. INFORMANT ADDRESS Jane B. Barger (same as 13e)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 Lung Cancer IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <input checked="" type="checkbox"/> the hospital attended the deceased from 4/20 , 19 78 , to 6/12 , 19 79 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 6/8 , 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE Stephen J. Newman			DEGREE MD			22c. DATE SIGNED 6/12/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman, M.D.			22e. ADDRESS Gaithersburg, Maryland 19261 Montgomery Village Avenue							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6-14-79		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BLADENSBURG P.G. MD.			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A			ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady			

15107

June 12, 1974 2:00 PM

15107

1911 Parkway Drive

15107

Jane H. Parker

Stephen J. Parker, Jr.
1911 Parkway Drive
Fairfax, Virginia 22031
613170

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elton Linwood Brumbley						2a. DATE OF DEATH MONTH DAY YEAR 6 8 79		2b. HOUR 8:20 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 3 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Bus	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring						13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 9104 Kingsbury Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Brumbley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Carter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-10-6877		17. INFORMANT Ruth I. Brumby Silver Spring, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) COPD and acute MI DUE TO, OR AS A CONSEQUENCE OF (c) 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/78 , 19____, to 6/8 , 19____, that (I) (we) last saw the deceased alive on 6/8/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH Ho						22e. ADDRESS 7600 Carroll Ave, Tk. Prk. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 11, 79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24a. DATE REC'D. BY REGISTRAR JUN 13 1979						24b. REGISTRAR'S SIGNATURE [Signature]			

Rev. D. E. Warner E. Pumphrey Inc. Silver Spring, Md.

ADDRESS

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Maryland U.S.A.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 5 1 6 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH DAY YEAR		7b. HOUR	
BERNARD		A.		BURKE, Jr.				6 13 79		3:13 a	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
				OCT 5, 1956		22 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
PENNSYLVANIA				U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
SILVER SPRING				12410 Layhill Rd.				MECHANIC			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MARYLAND				MONTGOMERY		WHEATON		13e. STREET ADDRESS 2610 URBANA DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
BERNARD A. BURKE				JOAN McKEOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				218-76-8909		BERNARD A. BURKE SAME AS 13 FATHER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest (handgun)</u> 9560 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 3:00 AM. 6 13 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot by police					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE on the lot next to 12410 Layhill Rd. Silver Springs, Md.					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant				DATE SIGNED			
				MEDICAL EXAMINER				6/13/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL				6/16/79		GATE OF HEAVEN				SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS				JUN 18 1979							
500 UNIV. BLVD., W., SILVER SPRING, MD.				20901							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					79 15170 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TERESA H BURNS.					2a. DATE OF DEATH MONTH DAY YEAR 6-30-79			2b. HOUR 12 ³⁰ A.M.		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 24, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITEV CHASE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND					13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE H. MICHAELSEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA H. PETSCH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. NONE		17 INFORMANT ADDRESS MRS. JANE VOGT RT1 CALLAO, VIRGINIA 22435			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4392 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) } Congestive heart failure (c) } Arteriosclerotic Cardiovascular d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs. Years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/30 1979, to 6/30 1979, that (I) (we) last saw the deceased alive on 6/30 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James R. Coleman MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-30-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN MD.					22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JULY 3, 1979		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME					ADDRESS SILVER SPRING, M.D.		25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 15171 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Lonnie (nmw) Burton								6-19-79		10 ²⁰ A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
M		B		3-26-1941		38 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S.C.		U.S.A.				Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
TAKOMA PARK		WASHINGTON ADVENTIST HOSP.		FOREMAN		ICE CREAM CO.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD.		P.G.		BENT PLEASANT		YES		#5 CINDY LN.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
THEODORE		JOHNSON		IDA MAE BURTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
No		247-66-1551		ILENE BURTON-327 SHERMAN DR., S.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>manipulation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metabolic gothic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>Dec 23, 1977</u> to <u>June 19, 1979</u> , that (1) (we) lost saw the deceased alive on <u>June 19, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>D.J. MAIDAK</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/19/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
D.J. MAIDAK		675 Belcrest Rd, Hyattsville									
23a. (BURIAL) CREMATION REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		6-21-79		PINE GROVE CEM.		ABEVIEW CO., S.C.					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.		JUN 25 1979		Lester A. Brandy							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15172																			
1. DECEASED NAME (TYPE OR PRINT) Florence M. Calhoun										2b. DATE KNOWN OF DEATH ESTIMATED June 25, 1979										2c. DATE PRONOUNCED DEAD June 25, 1979										2d. HOUR 7:00 PM																			
3. SEX F		4. RACE W		5. DATE OF BIRTH (MONTH DAY YEAR) Oct. 20, 1911		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD June 25, 1979										7d. HOUR 7:00 PM																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery																			
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Elizabeth's Hill Md										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Section Chief										12b. KIND OF BUSINESS OR INDUSTRY Vet. Adm.																			
13a. STATE Md										13b. COUNTY Mont.										13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS 6804 Richmond Ave									
14. FATHER'S NAME (FIRST MIDDLE LAST) John Francis MacGregor										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Florence Ellen Wallace										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 220-44-0947										17. INFORMANT Granddaughter ADDRESS 11102 Lombardy Rd. Silver Spring, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4292										IMMEDIATE CAUSE (a) Terminal Bronchitis / Pneumonia										2 yrs																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										(b) Arth. Cardio Vascular										yrs																													
										(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																	
Fracture L. Hip																																																	
19a. DATE OF OPERATION April 20, 78										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Prostheses										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) 4 April 1978										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home										21f. LOCATION (CITY OR TOWN STREET COUNTY STATE) Richmond Acc Silver Spring, Mont Md																													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE John S. Rogers										TITLE (SPECIFY) M.D. Dept										DATE SIGNED June 24, 1979																													
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers										ADDRESS 1919 Seminary Road Silver Spring, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Jun. 28, 1979										23c. NAME OF CEMETERY OR CREMATORY Rock Creek										23d. LOCATION (CITY OR TOWN COUNTY STATE) Washington, D.C.																			
24. FUNERAL DIRECTOR NAME Francis J. Collins										ADDRESS 500 University Blvd.; W. Silver Spring, Md.										25a. DATE REC'D. BY REGISTRAR JUN 29 1979										25b. REGISTRAR'S SIGNATURE Anthony M. Bandy																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 15173

1 DECEASED NAME (TYPE OR PRINT) Michael Patrick CANNON			2a DATE OF DEATH MONTH DAY YEAR May 25, 1979			2b HOUR 1:50aM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 24, 1979		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 5 1 17		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 17801 Buehler Road	
14 FATHER'S NAME FIRST MIDDLE LAST Robert Michael Cannon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Lee Horn			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxia 7689 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) unconscious by (c) premature labor			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ronald Smith</i>				DEGREE Medical Professional Building		22c. DATE SIGNED 5/25/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Smith, M. D.				22e. ADDRESS Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE May 25, 1979		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR JUL 10 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>			

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 15174

1. DECEASED NAME (TYPE OR PRINT) Perry			FIRST H			MIDDLE CARMAN			LAST Jr.			2a. DATE OF DEATH MONTH June DAY 30 YEAR 1979			2b. HOUR 7 20 P		
3 SEX male			4 RACE White			5. DATE OF BIRTH MONTH 10 DAY 19 YEAR 09			6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS 			IF UNDER 24 HRS. HOURS MIN 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10 CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Ins. Agent -			12b. KIND OF BUSINESS OR INDUSTRY Ins. Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. Geo. 13c. CITY OR TOWN E. Riverdale												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 6712 - Hamilton St.		
14 FATHER'S NAME FIRST Perry MIDDLE H. LAST Carman Sr.						15. MOTHER'S MAIDEN NAME FIRST Josephine A. MIDDLE McCusker LAST 											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 578-01-0745			17. INFORMANT ADDRESS Ethel M. Carman - same as above								
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST (Wife) DUE TO, OR AS, CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS, CONSEQUENCE OF (c) EMETASTASIS OAT CELL CARCINOMA OF LUNG XTNR CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PANHYPOTITISM																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from 15 JUNE , 19 79 , to 30 JUNE , 19 79 , that (b) I saw the deceased alive on 30 JUNE , 19 79 , and that in my opinion death occurred on the date and hour and from the causes stated above (1) <input checked="" type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4) <input type="checkbox"/> view the body after death.																	
22b. SIGNATURE W. Gerling						DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 30 June 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM GERLING						22e. ADDRESS 7600 CARROLL AVE T.P., MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 7/3/1979			23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.			23d. LOCATION CITY OR TOWN Clinton COUNTY Pr. Geo. STATE Md.					
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.						ADDRESS Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR JUL 2 1979			25b. REGISTRAR'S SIGNATURE L. K. B. B. B.					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Walker Carnduff					2a. DATE OF DEATH MONTH DAY YEAR June 2 1979 2b. HOUR 9:25 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 27 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Bethesda Cedar La.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher (Latin)		12b. KIND OF BUSINESS OR INDUSTRY Public Schools	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13e. STREET ADDRESS 7612 Clar ewdon Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST F. Lawrence Walker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Apphia Collins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-16-0782A		17. INFORMANT ADDRESS Mary Anne Frey, Dtr. 1009 Colwick Dr. Dayton, Ohio					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatoid Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7148									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from ~ 8 , 19 78 , to 5-30 , 19 79 , that (I) (we) last saw the deceased alive on 5-30 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Christopher Unger, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, M.D.					22e. ADDRESS 8218 Wisc. Ave., Bethesda, Maryland.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. ADDRESS 5139 WISC. AVE., N. W. WASH., D. C. 20018					25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Patricia McCready		

MEDICAL CERTIFICATION



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15176

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas L Carroll			2a. DATE OF DEATH MONTH DAY YEAR 6/3/79		2b. HOUR 2:27 AM						
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Feb 26 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seaboard Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Hardware			
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12630 Viers Mill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-1122A		17. INFORMANT ADDRESS Thomas R. Carroll 13904 Dowlais Dr., Rockville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Atherosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours years years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Failure, Electrolyte Imbalance											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/1, 19 79, to 6/3, 19 79, that (I) (we) last saw the deceased alive on 6/3, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jed Schelman				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/3/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jed Schelman				22e. ADDRESS 9410 Old Georgetown Road							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-6-79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Dorothy Schelley					

IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1 2 1 7 0



DATE 10-10-70

TO: Mr. J. Edgar Hoover, Director, FBI

FROM: Mr. [Name], [Address]

SUBJECT: [Subject Line]

[Body of the letter]

[Body of the letter]

[Body of the letter]

[Body of the letter]

[Body of the letter]

Very truly yours,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 79 15177				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alfred Carter</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>6 30 79</i>			2b. HOUR <i>6 A M</i>	
3 SEX <i>Male</i>		4 RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 10, 1910</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montg</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4509 Beland St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Carter</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>57A-10-8492</i>		17. INFORMANT ADDRESS <i>Samuel Carter - 521 CALVIN LANE Rockville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140 Congestive heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.									
22b. SIGNATURE <i>James E. Hutchinson</i> MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/30/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James E. Hutchinson</i>				22e. ADDRESS <i>Suburban Hospital, Bethesda Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7-6-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Pr. Geo, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>				24b. ADDRESS <i>246 N. Washington St. Rockville, Md. 20850</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John J. McCurdy</i>	

MEDICAL CERTIFICATION

5400 BP

1 2 1 1 1

George R. Snowden
Rockville, Md. 20850
Jul 2 1970
Lincoln Memorial Cem. Suitland, Pr. Geo. Md.
248 N. Washington St.
Rural 7-5-70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 15178	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST OLIVER B CASSELL			2a. DATE OF DEATH MONTH DAY YEAR 6 28 79			2b. HOUR 10:15 A M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug. 7, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C.			13b. COUNTY N/A		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1301 Delaware Ave. S.W.		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Cassell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-30-0857		17. INFORMANT ADDRESS Mercia C. Decker, 5 Harlow Ct., Rockville MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours - year.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>79</u> , to <u>6/28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jack P. Segal</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>6/28/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK P. SEGAL			22e. ADDRESS 5530 Wisconsin Ave Chevy Chase Md 20015								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 2, 1979		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.				
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, 1400 Georgia Ave. NW			25a. DATE REC'D. BY REGISTRAR JUL 8 1979		25b. REGISTRAR'S SIGNATURE <u>F. J. Kennedy</u>						

BP

8 9 1 2 1 4 1



Handwritten signature or initials.

200 100

Handwritten signature or initials.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15179	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Raymond Baani Caulker						2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 6-4-1979		2b. HOUR 1A M	
3. SEX M.	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1944		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 34 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD June 4 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sierra Leone		7b. CITIZEN OF WHAT COUNTRY? Sierra Leone Africa				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diplomat		12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Franklyn Caulker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecilia Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. O.W. Harding 1701-19th St. N.W. D.C. Wash.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Severe 8169 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) Trauma Auto Accident (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1200 am 6-4-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Lost control of Auto -					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7200 Blvd. Bradley Blvd Bethesda Montgomery Md					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Ball				TITLE (SPECIFY) DEPT				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE June 6, 1979		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE Freetowne, Sierra Leone	
24. FUNERAL DIRECTOR NAME ADDRESS John S. Ball 7400 Georgia Ave. N.W. WashDC				25a. DATE REC'D. BY REGISTRAR JUN 6 1979				25b. REGISTRAR'S SIGNATURE Patricia Kelly			

15178

Sept. 27, 1944

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St. Louis, Mo. 64110

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St. Louis, Mo. 64110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 15180			
1. DECEASED NAME (TYPE OR PRINT) BEULAH LILLIAN CHAMBERLIN				2a. DATE OF DEATH MONTH DAY YEAR JUNE 2, 1979			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 28, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (COUNTRY) TROY, NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH BETHESDA, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM NMN SMITH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELFIE C. WRIGHT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 108-01-0431-A		17. INFORMANT ADDRESS Chevy Chase, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK							
DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOR WALL MYOCARDIAL INFARCTION							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 28 MAY 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 28 MAY 19 79 to 2 JUNE 79 , that (I) (we) last saw the deceased alive on 2 JUNE 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE James J. Curran MD				22c. DATE SIGNED 6.3.79		22d. ADDRESS National Naval Medical Center Bethesda, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY OAKWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE TROY, NEW YORK	
24 FUNERAL DIRECTOR Robert A. Pumphrey NAME Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 6 1979			

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REVIEWS

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TRAINING

PLANT

THE NEW YORK PUBLIC LIBRARY

RESEARCH, JACQUES J. JACQUES, JR., M.D., JACQUES J. JACQUES, JR., M.D.

104 GILSON STREET

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BOOKS RECEIVED

INTELLIGENCE INFORMATION REPORT

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4.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7915181	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>AMELIA M Chaplin</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>JUNE 15 1979</i>		2b. HOUR <i>1 P M</i>
3. SEX <i>F</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 7 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ARGENTINA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>ARGENTINA</i>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.		10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Suburban Hosp.</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a. STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Juan Guillon Bird</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANN TWITTE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Juan Carlos Chaplin</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Massive Pleural effusion</i> (c) <i>Bronchogenic Carcinoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>4 weeks</i> <i>3 months</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive heart failure</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1st</i> , 19 <i>77</i> , to <i>June 15</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>June 14</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did) (did not) view the body after death.					
22b. SIGNATURE <i>Luis Bentolila M.D.</i>		DEGREE		22c. DATE SIGNED <i>6/15/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Luis Bentolila M.D.</i>		22e. ADDRESS <i>5480 Wisconsin Avenue.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>JUNE 25, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BRITISH CEMETERY</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>BUENOS AIRES ARGENTINA</i>		23e. DATE REC'D. BY REGISTRAR <i>JUN 19 1979</i>		23f. REGISTRAR'S SIGNATURE <i>Henry H. H. H.</i>	
24. FUNERAL DIRECTOR NAME <i>CHAMBERS FUNERAL HOME</i>		ADDRESS <i>SILVER SPRING, MD.</i>			

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JUL 1 1881
BURNS RIVER HESPERIA

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15182

1 - FOR
STATE
REGISTRAR

CHERNER

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
LEON		CHERNER		6		1 79		1:30 a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		CAUCASIAN		MONTH DAY YEAR		75		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
RUSSIA		AMERICA				Montgomery County		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		FERNWOOD HOUSE		RETIRED		Auto Dealer			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
D.C.				WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4200 MASS. AVE. N.W.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
Harry		Cherner		Hattie		(Unknown)		Bethesda, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease, Non Htgkin.</u> (c) <u>Lymphoma, anemia</u> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral vascular disease, Prostatic Cancer, diabetes</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
						21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>78</u> , to <u>June 1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Charles B. Abrams</u>		22c. DATE SIGNED 6/1/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Charles B. Abrams		22e. ADDRESS 2141 K St. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6-3-79		Tifereth Israel		Hyattsville, P. G. Maryland			
24 FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE RECEIVED BY REGISTRAR			
Danzansky-Goldberg Mem. Chap. Rockville, Md.		1170 Rockville Pike ADDRESS		JUN 4 1979					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 15183 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CATHERINE C. COLBERT								6 26 79		10 ⁰⁵ P M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS (LAST BIRTHDAY))		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN	
F		BLACK		Dec. 22, 1899		79 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Kensington		Circle Manor Nursing Home									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Housewife		Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Prince George						Old Fort Road			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
William Clark		Lucy Whitlock									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No		577 26 5547		Ernestine Webb Washington, D.C. 20009							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Cerebrovascular Accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease										year.	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebrovascular Accident											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 11 1977, to June 26 1977, that (I) (we) last saw the deceased alive on June 21 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Beno Amin, M.D.						6-27-77					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Beno Amin, M.D.		3720 Farrington Ave. Ken, Md. 20755									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/30/79		Grace Cemetery		Chapel Hill, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT G. MASON, INC. - WASHINGTON, D.C.						JUN 29 1979		R. G. Mason			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 5 1 8 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ARTHUR W. Collins					2a. DATE OF DEATH MONTH DAY YEAR 6-27-79			2b. HOUR 1:25 M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7 29 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Govt.,	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2928 Marlow Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Buford Collins					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Douglas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 019-14-3983		17. INFORMANT ADDRESS Lucille O. Collins-wife-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 19, 1979 to June 27, 1979 , that (I) (we) last saw the deceased alive on June 27, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I just did not view the body after death.)									
22b. SIGNATURE Boo K. Kim					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 27 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim					22e. ADDRESS 19261 Mont Village Ave.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-30-79		23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cemetery New Haven Conn.,			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. PREPARED BY NAME Warner E. Pumphrey, Jr. 8434 Ga. Ave., S.S. Md.					25a. DATE REC'D. BY REGISTRAR JUL 2 1979 25b. REGISTRAR'S SIGNATURE History McCreedy				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 15185

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace E. Conners			2a. DATE OF DEATH MONTH DAY YEAR 6 27 79		2b. HOUR 4:45 P
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Jan 10 31	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montg.	13c. CITY OR TOWN Boysds	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21409 Clarkesburg Ave.
14. FATHER'S NAME FIRST MIDDLE LAST James C. Reed		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-26-4238		17. INFORMANT ADDRESS David N. Conners P.O. Box 195 Mt. Airy, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Come due to Brain metastasis 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 6 lines from breast metastasis 72 years.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July , 19 77 , to June , 19 79 , that (I) (we) lost saw the deceased alive on 6/27/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Elva Martinez		DEGREE M.D.		22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elva Martinez		22e. ADDRESS 8808 Hidden La., Potomac, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-30-79	23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Md.
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 9 1979 [Signature]		
P.A., Bethesda, Maryland					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 7915186				
1. DECEASED NAME (TYPE OR PRINT) Eva Pearl Conway					2a. DATE OF DEATH MONTH DAY YEAR June 2 1979			2b. HOUR 4 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 28, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. Geo's 13c. CITY OR TOWN Mt. Rainier					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4208 28th Street		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Duncil					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Carpenter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-54-1685		17. INFORMANT ADDRESS Dorothy J. Conway (dau) same as blk 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4286 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Lower GI bleeding DUE TO, OR AS A CONSEQUENCE OF (c) CNF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days see med
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD Sen Anterior dissection urinary tract infection									
19a. DATE OF OPERATION NO		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5-21 , 19 79 , to 6-2 , 19 79 , that (we) lost saw the deceased alive on 6-1 , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. N. Sandstrom MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. N. Sandstrom				22e. ADDRESS 7701 Carroll Ave TLK PR, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 5, 79		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Farmington Marion W. Va			
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, PA ADDRESS Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady			

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as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15187

M

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Helen L. Cooke			2a. DATE OF DEATH MONTH May DAY 5 YEAR 79		2b. HOUR 12⁰⁰ P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH July DAY 21 YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MD.		13b. COUNTY Pr. Goerge Hillcrest Hts.		13c. STREET ADDRESS 4013 21st Place	
14. FATHER'S NAME FIRST William MIDDLE - LAST Brown		15. MOTHER'S MAIDEN NAME FIRST Addie MIDDLE - LAST Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. 579-18-6679		17. INFORMANT J. James Cooke ADDRESS Same as #13 a-e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 485- DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 4 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 19 78 to 5 MAY 19 79 , that (I) (was) last saw the deceased alive on 5 MAY 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE Walter E. Goode MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5 May 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODE MD		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 5, 1979		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l.	
23d. LOCATION CITY OR TOWN Suitland		COUNTY P.G.		STATE Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1979	
		25b. REGISTRAR'S SIGNATURE Petry			

MEDICAL CERTIFICATION

12187

(M)

Handwritten notes on lined paper, including "Coke", "12187", and "12187".

Handwritten notes on lined paper, including "12187", "12187", and "12187".



DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										JOHN B. LUTHER 808 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Luther Cope										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6-14-79		2b. HOUR 7 P	
3. SEX M.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-28-1913		6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Clarksburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12001 Skyline Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIGHTING SALESMAN (RET.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7311 MAPLE AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST LUTHER COPE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. W.W.T. 577-07-7434		17. INFORMANT ADDRESS MARJORIE A. COPE, 7311 MAPLE AVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Cardio-vascular Disease (b) Cardio-vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John B. Hall				TITLE (SPECIFY) Deputy				DATE SIGNED June 15, 1979					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 18, 1979				23c. NAME OF CEMETERY OR CREMATORY Geary Washington Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Prince Georges Md	
24. FUNERAL DIRECTOR Takoma Funeral Home, J. J. Hall, 2840 Conn. Rd. NW DC				25a. DATE RECD. BY REGISTRAR JUN 18 1979				25b. REGISTRAR'S SIGNATURE Henry McCready					

88-121-921

Clarkson 1201 24th Ave

Colon and T. nuttalliana A. C. 25

Property

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 15189	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert E. Copeland					2a. DATE OF DEATH MONTH DAY YEAR 6 - 21 - 79				2b. HOUR 3:40 A.M.		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR FEB 8, 1909		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER-PARTNER		12b. KIND OF BUSINESS OR INDUSTRY CAMPBELL SAND & GRAVEL CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9305 COMPTON STREET			
14 FATHER'S NAME FIRST MIDDLE LAST CLYDE C. COPELAND					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES E. ALLEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-10-5088		17 INFORMANT OPAL M. COPELAND		ADDRESS SAME AS 13		WIFE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest. 5938 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Vascular occlusion renal arteries										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed. 4 days. 6 days.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James R. Coleman MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. COLEMAN MD				22e. ADDRESS 2241 COLUMBIA BLVD SILVER SPRING MD. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/23/79		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SHILLINGTON BERKS PA					
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 15190	
1- FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nettie - Coe</i>			2a DATE OF DEATH MONTH DAY YEAR <i>6-27-'79</i>		2b HOUR <i>1:45 AM</i>
3 SEX <i>female</i>	4 RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 10 1884</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>94</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Michigan</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10 CITY OR TOWN OF DEATH <i>Kensington</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kensington Gardens N. Home</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY <i>own home</i>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i> 13b COUNTY <i>Pr. George</i> 13c CITY OR TOWN <i>Hyattsville</i>		13d INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <i>902 Cox Avenue,</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Vanpelt</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alvira (unknown)</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO <i>577-09-3643</i>		17 INFORMANT ADDRESS <i>Jeanette Wilson-daughter-(same as 13e)</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>20 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22 I certify that (I) (this hospital) attended the deceased from <i>Nov 19 20</i> to <i>22 June 19 29</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>22 June 19 29</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.					
22a SIGNATURE <i>John M. W. M. M. M.</i>		DEGREE <i>no</i>		22c DATE SIGNED <i>6/27/79</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>John M. W. M. M. M.</i>		22e ADDRESS <i>7801 Norfolk Ave Bethesda, MD 20814</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>6-29-79</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
23d LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Pr. Georges Md</i>		23e DATE REC'D. BY REGISTRAR <i>JUL 2 1979</i>			
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25b REGISTRAR'S SIGNATURE <i>Barry McCreedy</i>			
24a ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>					

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FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 15191

1. DECEASED NAME (TYPE OR PRINT) FIRST M MARGARET MIDDLE VIRGINIA LAST CRAIG			2a. DATE OF DEATH MONTH DAY YEAR 6 - 4 - 79		2b. HOUR 4 30 P M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 29 03		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3720 Manor Road				
14. FATHER'S NAME FIRST James MIDDLE Vance LAST Craig			15. MOTHER'S MAIDEN NAME FIRST Bessy MIDDLE Pillsbury LAST								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-05-7127		17. INFORMANT Sister.			ADDRESS Silver Spring, Md. Mildred C. Carroll, 2304 Dexter Ave.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart disease 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none											
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 29 May 1979 to 4 June 1979, that (I) (we) lost saw the deceased alive on 4 June 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David B. Kessler			DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4 June 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David B. Kessler, M.D.			22e. ADDRESS 10620 Gerogia Ave., Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/6/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. ADDRESS 5120 WISG. AVE., N. W. WASH., D. C. 20016			25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy						

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 15192	
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) H Roger Crist						2a. DATE OF DEATH MONTH DAY YEAR June 3, 1979		2b. HOUR 10:30p			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 13, 1907		6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY West. Va. Morgan Berkeley Springs				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS Fairview Drive R. R. 4, Box 219					
14. FATHER'S NAME FIRST MIDDLE LAST Howard Preston Crist				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Breedlove		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 577-01-6189		17. INFORMANT Lewis R. Crist				18. ADDRESS 104 Embassy Lane Kirkwood, MO 63122					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic obstructive lung disease gastrointestinal bleeding</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <u>5/14</u> , 19 <u>79</u> , to <u>6/3</u> , 19 <u>79</u> , that (b) (we) last saw the deceased alive on <u>6/3</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (c) (we) (did not) view the body after death.											
22b. SIGNATURE <u>John G. Lodmell MD</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL				22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-6-79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland			
25a. DATE REC'D. BY REGISTRAR JUN 8 1979				25b. REGISTRAR'S SIGNATURE <u>John G. Lodmell</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND										1 5 1 9 3		A.M.				
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First Chong			Middle Moe			Last Dan			2a. DATE OF DEATH Month June Day 26 , 1979 Year			2b. HOUR 7:10	
3. SEX Male			4. RACE Chinese			5. DATE OF BIRTH Dec. 26, 1906			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign) Tso Chow, China			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery							
10. CITY OF TOWN OF DEATH Takoma Park, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sligo Gardens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. owner China Star Cafe			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Mont			13c. CITY OR TOWN Sil.Sp.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 9305 New Hampshire Ave				
14. FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes (If yes, year or dates of service) WWII										
16b. SOCIAL SECURITY NO. 051-18-8905			17. INFORMANT Silver Spring, Md. 20903 Lamont John Dan-son 9305 New Hampshire Ave													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71 year > 1 yr																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 6/23 , 1979, to 6/26 , 1979, that (I) (we) last saw the deceased alive on 6/23/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Deborah B. Goldberg MD			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/26/79							
22d. PHYSICIAN'S NAME (Type) Deborah B. Goldberg, M.D.			22e. ADDRESS 1106 Spring St. Silver Spring, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 29, 1979			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.							
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002			25a. REC'D BY REGISTRAR DATE JUN 27 1979			25b. REGISTRAR'S SIGNATURE Anthony McCreedy										

Lee Funeral Home 300-4th St N.E. Wash. D.C.

Burial June 29, 1979 Fort Lincoln Cemetery

Colon Manor, Md

Deborah B. Goldberg, M.D.

Yes

Will

071-18-8907

Lambert John Dawson 9305 New Hampshire Ave

Silver Spring, Md 20907

Unknown

Unknown

Md

Mont

811 Sp

x

9305 New Hampshire Ave

T. Silver Spring, Md. 8110 Garden Nurseries Home Bldg. across China State Cafe

Woo Chow, China USA

xx

Montgomery

Male Chinese

Dec. 28, 1906

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Chong

Joe

Don

June 28, 1979

7:10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15194	
1. DECEASED NAME (TYPE OR PRINT) Charles Gregory Davenport										2a. DATE OF DEATH KNOWN OF ESTI- MATED <input type="checkbox"/> June 11 1979										2b. HOUR 1015 am	
3. SEX Male		4. RACE Cauca		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1954		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 24		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD June 11 1979		2d. HOUR 6pm									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1605 Gruenther Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Installer				12b. KIND OF BUSINESS OR INDUSTRY Fences									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1605 Gruenther Avenue													
14. FATHER'S NAME FIRST MIDDLE LAST Jesse C. Davenport					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Price																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 219-64-5561					17. INFORMANT ADDRESS Jesse C. Davenport, Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Wound of chest. 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Self inflicted. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:24 6-11-79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot Self with Hand gun.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1605 Gruenther Ave. Rockville Md. Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. DePoty MEDICAL EXAMINER				DATE SIGNED June 12, 1979													
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Bethesda Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/14/79				23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Maryland									
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, PA, ROCKVILLE, MARYLAND								25a. DATE OF BURIAL JUN 19 1979				25b. REMARKS See pg. 2 of record									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										15195													
1- STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)					FIRST Charles					MIDDLE E.					LAST Davis					2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		2 15 1892		6. AGE (IN YEARS) LAST BIRTHDAY		87 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		6/24/ 1979		2d. HOUR		23 PM											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					DC					7b. CITIZEN OF WHAT COUNTRY?					USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					Montgomery County MD.						
10. CITY OR TOWN OF DEATH					Bethesda					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					Suburban Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Ret. Financial Exec.		12b. KIND OF BUSINESS OR INDUSTRY		Construction							
13a. STATE										13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
md										MONT					CHEY CHASE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4001 ROSEMARY ST											
14. FATHER'S NAME FIRST MIDDLE LAST					Charles Davis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					Rose Hammer																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					No					16b. SOCIAL SECURITY NO.					577-01-9716					17. INFORMANT					Wife					ADDRESS		Louise Reilly Davis, Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 HRS 20+ YRS																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY?													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																							
					P.M. 6 24 1979					COLLAPSED HEART																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
					HOME					4001 ROSEMARY ST CHEY CHASE MONT MD																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																	
ACTUAL SIGNATURE					F. C. MAYLE										M.D. Dr. A. B. WISNIEWSKI					DATE SIGNED		6/24/79											
EXAMINER'S NAME (TYPE OR PRINT)					F. C. MAYLE										ADDRESS					520 Wisconsin Ave Bethesda MD 20814													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION																		
Burial					6/28/1979					New Cathedral Cemetery					Baltimore, Maryland.																		
24. FUNERAL DIRECTOR NAME					JOSEPH CAWLER'S SONS INC.										25a. DATE REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE													
					5139 WISSE AVE, N. W. WASH, D. C. 20010										JUL 2 1979					Dorothy McCreedy													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 5 1 9 6 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rose K. Dawson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>6/13/79</i>			2b. HOUR <i>8:30 A.M.</i>		
3. SEX <i>FEMALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>JUNE 11 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>SOUTH DAKOTA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.				
10. CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>817 ROCKVILLE PIKE</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>RET. SUPERVISOR OF ELECTIONS</i>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>					13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>ROCKVILLE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>HENRY A. DAWSON</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FRANCES WILLIAMS</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-40-6316</i>		17. INFORMANT ADDRESS <i>JANET KIRBY 7716 WARBLER LA., DERWOOD, MD.</i>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Thrombosis & Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15'</i> <i>1 hr</i> <i>10 yrs</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>C.V.A., Aortic Aneurysm, N.B.P.</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>4/10/51</i> to <i>6/13/79</i> , that (I) (we) lost saw the deceased alive on <i>6/7/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Stephen N. Jones</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <i>6/13/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN N. JONES, M.D.</i>					22e. ADDRESS <i>809 VIERS MILL RD., ROCKVILLE, MARYLAND 20850</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6-16-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCKVILLE CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROCKVILLE MONTG. MD.</i>				
24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>FUNERAL HOMES P/A MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>				

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15197			
1. DECEASED NAME (TYPE OR PRINT) IRENE MARY DAY										2a. DATE KNOWN OF DEATH ESTIMATED 6 25 1979		2b. HOUR A	
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 1 08 33 46		6. AGE (IN YEARS) LAST BIRTHDAY YRS 46		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 25 1979		2d. HOUR 230	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLONIAL MANOR MOTEL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER				12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SPRINGFIELD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11404 IDLEWOOD RD					
14. FATHER'S NAME FIRST MIDDLE LAST Fred Doeseckle						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Horne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 067 28 4767		17. INFORMANT Kenneth Day				ADDRESS 122 Calvert Rd. Rockville Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVERDOSE 9509 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DEPRESSION DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE YEARS													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION 7				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 5				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 25 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) TOOK PILLS + ALCOHOL					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) MOTEL				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11404 Rockville Rd. Rockville MONT MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE SPECIFY Deft MEDICAL EXAMINER DATE SIGNED 6/25/79 SIGNATURE F. C. MAYLE ADDRESS 8200 W. KENNESAW AVE BETHESDA MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/2/79		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Lackawanna, New York			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, PA BETHESDA MARYLAND						25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTERED Marking					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 15198	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) J. BLAISE deSIBOUR				2a. DATE OF DEATH MONTH DAY YEAR June 16, 1979			2b. HOUR 9:15P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23 1905		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4978 Sentinel Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4978 Sentinel Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Jules Henri deSibour				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Margaret Clagett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW1		17. INFORMANT Son J. BlaisedeSibour.		ADDRESS 2707--34th Pl., N.W. Wash D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 4140 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Asteroidotic Heart Dis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Week 5 Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>6-16</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard B. Perry				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED June 16, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard B. Perry				22e. ADDRESS 1145-19th St., NW, Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/18/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland.				
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER & SONS INC. 5128 WISB AVE. N. W. WASH. D. C. 20018						25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Rickey McCreedy			

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Item 4, per tel. conv. w/f.h.
FOR 6/12/79 bal
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 15199

1 DECEASED NAME (TYPE OR PRINT) FIRST (Hillian) LAST Constance E. Dodson		2a DATE OF DEATH MONTH DAY YEAR 6-5-79		2b HOUR 6:35 PM	
3 SEX Female	4 RACE White BLACK	5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash... D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Va.		13b. COUNTY Fairfax	13c. CITY OR TOWN Reston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Van		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Danies			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-54-2449		17. INFORMANT 11506 Maple Ridge Rd. Obie C. Dodson, Reston, Va. (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - cardio-pulmonary failure 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) due to, or as a consequence of widespread metastatic ca to lungs, etc (c) due to, or as a consequence of Carcinoma of breasts					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) -	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -	
22a. I certify that (I) (this hospital) attended the deceased from 5/30 19 79 to 6/5 19 79 , that (I) (we) last saw the deceased alive on 6-5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Shamim MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-5-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. SHAMIM		22e. ADDRESS 200 Ft. Meade Rd. - Laurel, MD 20810			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY Met. Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		23e. DATE REC'D. BY REGISTRAR JUN 11 1979			
24. FUNERAL DIRECTOR NAME Green Funeral Home, 721 Elden St., Herndon Va.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15200	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) DANIELLE Louise DONATELLI						2a. DATE OF DEATH MONTH DAY YEAR June 10, 1979			2b. HOUR 3:50AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 26, 1964		6 AGE (IN YEARS LAST BIRTHDAY) 14 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, MD NIH				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b KIND OF BUSINESS OR INDUSTRY N/A			
13a STATE Pennsylvania						13b COUNTY Lehigh		13c CITY OR TOWN Bethlehem		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas D. Donatelli						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan L. Turan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Mrs. Joan Donatelli, Mother (Same as 13)					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Respiratory Distress (c) Acute Lymphocytic Leukemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 3 Weeks 9 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (16)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that X (this hospital) attended the deceased from May 17, 1979, to June 10, 1979, that X (we) lost saw the deceased alive on June 10, 1979, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (not) view the body after death.											
22b. SIGNATURE Curt I. Civin						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Curt I. Civin						22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, MD 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-13-79		23c. NAME OF CEMETERY OR CREMATORY Bethlehem Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Bethlehem, Pennsylvania			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE			

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(M)



FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				15201 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR		2d. HOUR							
Raymond W. Dorsey								6-18-79		1979		A M							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR							
M.	B.	Dec. 27, 1908		70 YRS.		MONTHS DAYS HOURS MIN				June. 18, 1979		7 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Md.		U.S.A.				Montgomery MD													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		6501 Bells Mill Rd.																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Md.		Montg.		Bethesda				6501 Bells Mill Rd.											
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																	
Richard Dorsey		Lillie Pratt																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS															
Yes		IWWII		579-05-7026		Irene Mahoney - Rockville Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 411- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Cardio. Vascular Disease -</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. NAME OF CEMETERY OR CREMATORY		22c. LOCATION CITY OR TOWN COUNTY STATE															
Burial		6-21-79		Lincoln Park Cem.		Rockville		Montg		Md.									
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
George R. Snowden		246 N. Wash. St. Rockville, Md.		JUN 21 1979		Henry McCready													

1 0 5 0 1

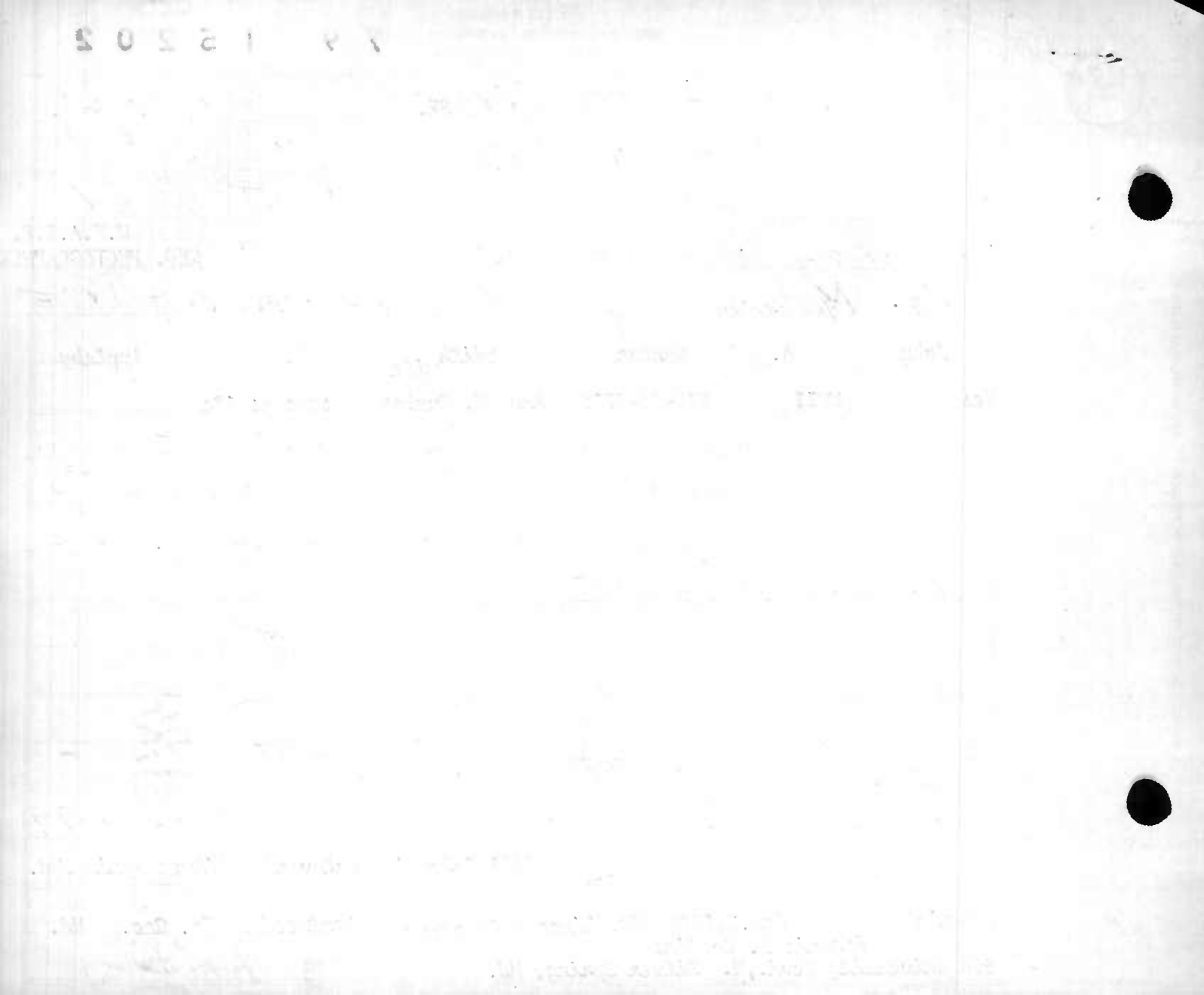


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15202			
1. FOR STATE REGISTRAR				3a. DATE OF DEATH MONTH 6 DAY 4 YEAR 79			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN A. DUNBAR SR.				3b. HOUR 12 ⁴⁶ PM			
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 9 DAY 23 YEAR 74		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS YEAR) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY W.R.A.T.R. MED. PHOTOGRAPHER	
13a. STATE Md.				13b. STREET ADDRESS 8302 PARKCREST DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST John A. Dunbar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith H. Appleby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 578-32-5710			
17. INFORMANT wife				ADDRESS same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), add (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) shock, congestive heart failure 12 hrs (c) acute myocardial infarction 36 hrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH terminal							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) advanced HCVD.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 6-4 19 79, that (I) () last saw the deceased alive on 6-4 19 79, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did) () view the body after death.							
22b. SIGNATURE George Sengstack				DEGREE		22c. DATE SIGNED 6-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Sengstack				22e. ADDRESS 9241 Columbia Boulevard, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun. 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR Francis J. Collins				25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE [Signature]	
500 University Blvd., W. Silver Spring, Md.							



Items #10a-22a Film G533 7/18/79 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15203

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			MONTH DAY YEAR			2d. HOUR		
CHRISTOPHER R. DUNGAN						6 19 79						8:10		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
male	white	Jan. 17 1952	27 RS.	MONTHS	DAYS	6 19 79						8:10		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Washington, DC			USA						Montgomery Co.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross Hospital			Electrician Apprentice			Electricians					
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			11910 Dalewood Drive					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
James A. Dungan			Anna Pappas			no			215-46-2676			Anna Simpson-mother-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Acute narcotism</u>														
3049 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			6-19-79					
Ann M. Dixon, M.D.			Assistant											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
			111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			6-21-79			Parklawn Cemetery			Rockville Montgomery Md.					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Warner E. Pumphrey, Inc.			JUN 22 1979			[Signature]								
8434 Ga. Ave., S.S. Md.														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 15204	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret J. Duvall					2a. DATE OF DEATH MONTH DAY YEAR June 1, 79			2b. HOUR 12 ¹⁷ P.M.			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6-23-12		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. UNDER 1 YEAR MONTHS DAYS 66		8. UNDER 24 HRS. HOURS MIN. 12 17	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY GEICO		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DIST. OF COL.										13b. COUNTY D.C.	
13c. CITY OR TOWN WASH., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4319 ALTON PLACE, N.W.							
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM T. TAGGART				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA SWEET							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 578-09-5153A		17. INFORMANT ADDRESS BARBARA A. NOLTE 4 SHERRY CT., ROCKVILLE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) MEDIASTINAL METASTATIC CARCINOMA, PRIMARY UNKNOWN											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-2-79 , to 6-1-79 , that (I) (we) last saw the deceased alive on 6-1-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death.)											
22b. SIGNATURE Robert A. Pumphrey						DEGREE MD		22c. DATE SIGNED 6/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Pumphrey						22e. ADDRESS 7801 Rockville Ave. Bethesda, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-5-79		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN MEM. PARK			23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTG MD.				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

10521

61-85-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7a. DATE OF DEATH		MONTH		DAY		YEAR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7b. HOUR	
SUZANNE GRACE		EDSON						7. P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		WHITE		NOV 11 1885		93 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
VERMONT		U. S. A.				Montgomery County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park Md		Sligo Gardens Nursing Home		ATTORNEY		U. S. GOVT.			
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
17		WASH., D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2039 NEW HAMPSHIRE AVENUE, N.W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
MILTON		EDSON		ELLEN		BRYANT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
NO		5-29-60-7497		ATTORNEY		806 15th ST. WASHINGTON, D.C.			
		KX7XX7KX7KX7K		JEREMIAH A. COLLINS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4409		Arteriosclerotic Vascular Disease		Cardiac Decompensation				4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-25-75 19 75, to June 1 1979, that (I) (we) lost saw the deceased alive on 5-31-79 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Elizabeth E. Chickering M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-1-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Elizabeth E. Chickering		3601 Conn. Ave Washington DC 20008							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL		JUNE 9, 1979		LUDLOW CEMETERY		LUDLOW		VERMONT	
24. FUNERAL DIRECTOR'S NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		JUN 5 1979		L. J. McReady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 15206

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorothy B Elliott			2a. DATE OF DEATH MONTH DAY YEAR June 28 1979			2b. HOUR 5 30 PM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR APRIL 5 '65		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Duplicating Co.		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Thomas Beavers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Selby			13e. STREET ADDRESS 3713 Decatur Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-18-9237		17. INFORMANT ADDRESS B. Madeline Beavers (Same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 2041 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>pneumonia, sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>chronic lymphocytic leukemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Organic brain syndrome</u> 71 yr.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1978</u> , 19 <u>79</u> , to <u>June 28</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 24</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Deborah B Goldberg</u>				DEGREE MD				22c. DATE SIGNED 6/28/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Deborah B Goldberg</u>				22e. ADDRESS <u>1106 Spring St. Silver Spring Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-3-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 9 1979 <u>Henry McCreedy</u>					

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 2 0 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHRISTOPHER KNIGHT			2a. DATE OF DEATH MONTH 6 DAY 10 YEAR 79			2b. HOUR 3:32 AM				
3 SEX Male		4 RACE WHITE		5. DATE OF BIRTH MONTH 6 DAY 9 YEAR 79		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 9 1 34		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD					13b. COUNTY P. G.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Nino MIDDLE F LAST ENKIRI					15. MOTHER'S MAIDEN NAME FIRST NANCY MIDDLE LEE LAST KNIGHT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS NINO F. ENKIRI SAME AS 13 FATHER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and cardiac arrest 7597 DUE TO, OR AS A CONSEQUENCE OF: (b) Immaturity and prematurity DUE TO, OR AS A CONSEQUENCE OF: (c) multiple anomalies								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Multiple anomalies										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 9th 19 79 to June 10 19 79 , that (I) (we) last saw the deceased alive on June 9th 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 5 - Mahallati					DEGREE MD			22c. DATE SIGNED 6-10-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 5 - MAHALLATI MD					22e. ADDRESS 6201 GREENBELT RD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/12/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHRISTOPHER KNIGHT

WHITE

W/A

LEE

WIND F. EVERTS SAME AS 13 FATHER



COSTON

STEVEN STING MONT

DATE OF DEATH

6/10/70

FRANCIS J. COLLINS

FOR UNIV. BLVD. W. STEVEN STING, NO. 20001

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 2 0 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Harry Palmer Ennis			2a. DATE OF DEATH MONTH DAY YEAR June 15, 1979			2b. HOUR 11:15			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan, 12, 1943		6 AGE (IN YEARS LAST BIRTHDAY) 36 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, (NIH)		12a. USUAL OCCUPATION (KING LIFE) Maintenance Department		12b. KIND OF BUSINESS OR INDUSTRY Municipal			
13a. STATE New Jersey		13b. COUNTY Monmouth		13c. CITY OR TOWN Spring Lake		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 812 Jersey avenue	
14 FATHER'S NAME FIRST MIDDLE LAST NOT AVAILABLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					
16b. SOCIAL SECURITY NO. 142-30-7101		17 INFORMANT ADDRESS same as above		17b. MRS. Muriel Ennis (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic melanoma 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 10, 1979 to June 15, 1979 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 15, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do) view the body after death.									
22b. SIGNATURE Kenneth Cowan		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Cowan		22e. ADDRESS National Institutes of Health The Clinical Center, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY Atlantic View Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Manasquan, New Jersey 20205			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b. ADDRESS Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, MD		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					MILTON H. SAGERSTROM REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MILTON SMITH Elmer E. Fagerstrom					2a. DATE OF DEATH MONTH DAY YEAR 6 24 79			2b. HOUR 10:45 P.M.	
3. SEX M.		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 5 08		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Takoma PK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Bank	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY TK, PK		13c. CITY OR TOWN Mont.		13e. STREET ADDRESS 807 Houston Ave TK PK, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Anton Fagerstrom					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Carlson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 122-07-1657		17. INFORMANT Alice J. Fagerstrom (13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and pulmonary arrest. 4/49 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) Severe persistent ventricular arrhythmia gave rise to immediate } cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF underlying cause last } (c) Coronary artery disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 1979 to June 1979, that (I) (we) lost saw the deceased alive on 6/24/79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Smith H. M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH S. HO M.D.						22e. ADDRESS 8323 Haddon Dr. Takoma Park Md 20012			
23. BURIAL CREMATION REMOVAL			23a. DATE			23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION CITY/TOWN COUNTY	
Burial June 28-1979			St. Luke's			Bethesda		Phos. Md.	
24. FUNERAL DIRECTOR K. H. H. H.			25. DATE REC'D. BY REGISTRAR 254			25b. REGISTRAR'S SIGNATURE K. H. H. H.		25c. DATE REC'D. BY REGISTRAR JUN 28 1979	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					79		15210	
1. FOR STATE REGISTRAR					REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Herbert Feay</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>6 13 79</i>			2b. HOUR <i>4 15 P M</i>
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5- 12 1902</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Cherry Chase Convalescent Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Actuary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Md.</i>					13c. CITY OR TOWN <i>Montgomery</i>		13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>1502 EAST West Highway</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Edmond Feay</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hilma Emelia Lundquist</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>					16b. SOCIAL SECURITY NO. <i>124-26-7378</i>		17. INFORMANT ADDRESS <i>Genevieve F. Feay - Same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis of the liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i> <i>10 yrs +</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Carcinoma of the Prostate</i>								
19a. DATE OF OPERATION <i>5/15</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>5/11</i> 19 <i>79</i> to <i>6/13</i> 19 <i>79</i> , that (1) (we) lost (a) the deceased alive on <i>6/11</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) we (did) (did not) view the body after death.								
22b. SIGNATURE <i>George S. Kenton, MD</i>					DEGREE <i>MD</i>		22c. DATE SIGNED <i>6/13/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GEORGE S. KENTON</i>					22e. ADDRESS <i>10620 GEORGIA AVE, S.S., Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>6-13-79</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>ANATOMY BOARD OF MD. Baltimore, Md.</i>					25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 15211							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace H. Federmann						2a. DATE OF DEATH MONTH DAY YEAR June 16, 1979		2b. HOUR MIN 12:35 P.M.	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov 7 1890		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Furnwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3382-Chiswick Crt.	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel E. Holmes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adra Kimble					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 310-16-9645		17. INFORMANT ADDRESS Patricia Evans 14514 Manor Park Dr. Rockville, Maryland 20853					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) repeated Myocardial Infarcts APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from February 19 64 to 16 June 79 , that (I) (we) lost the deceased alive on May 30 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, I so certify.)									
22b. SIGNATURE Michel M. Healy MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-16-79	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Michel M. Healy				22e. ADDRESS 5411 Cedar Ln. Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-17-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Va.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

12511



June 10, 1979

Holmstrom

Tracy

4-10-79

Bill Holmstrom, Jr.

Michael A. Henry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MILDRED FELDMAN					2a. DATE OF DEATH MONTH DAY YEAR JUNE 1 1979			2b. HOUR 7:05P^M	
3. SEX F^{Female}		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing & Con. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE D.C.		13b. COUNTY Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4201 Cathedral Ave., N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Katz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rae Michaelson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 579-05-4182 A		17. INFORMANT ADDRESS Cabot Feldman Husband. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized & Cerebral Arteriosclerosis 4370 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 YRS.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) FRACTURE (OLD) LEFT HUMERUS & LEFT HIP									
19a. DATE OF OPERATION 1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from NOV 19 78 to JUNE 1 19 79 , that (I) (we) last saw the deceased alive on MAY 29 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.									
22b. SIGNATURE Lawrence J. Thomas, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE J. THOMAS				22e. ADDRESS 11801 ROCKVILLE PIKE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/4/1979		23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER & SONS INC.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Patrick McCreedy			

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH15213
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANET				FIRST S.				MIDDLE FELKER				LAST				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> June 18, 1979				2b. HOUR 11:15											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH April DAY 16 YEAR 1935		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD June 18, 1979				2d. HOUR 11:15															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery																			
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5313 Hampden Lane								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Home															
15a. STATE Md.																13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 5313 Hampden Lane			
14. FATHER'S NAME FIRST Floyd MIDDLE G LAST Summers								15. MOTHER'S MAIDEN NAME FIRST Frances MIDDLE Eddy LAST Eddy																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 496-38-0758				17. INFORMANT Jr. Lansing R. Felker, 5313 Hampden Lane,																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma 2028 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. DePety				MEDICAL EXAMINER				DATE SIGNED June 18, 1979																			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd, Beth., Md.																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/21/1979				23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery				23d. LOCATION CITY OR TOWN St. Louis, Mo. COUNTY STATE																			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC.				25a. DATE REC'D. BY REGISTRAR JUN 25 1979				25b. REGISTRAR'S SIGNATURE Anthony McCreedy																							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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Figure 1. (a) Schematic of the experimental setup. (b) Schematic of the experimental setup.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15214

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carolyn Selina Foreman			2a. DATE OF DEATH MONTH DAY YEAR 06 05 79		2b. HOUR 1:50AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1896		
6. AGE (IN YEARS LAST BIRTHDAY) 82		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8. AGE UNDER 1 YEAR MONTHS DAYS YRS		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. IF UNDER 24 HRS. HOURS MIN.		
12. CITY OR TOWN OF DEATH Olney		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
15. USUAL RESIDENCE (IF MISSING HOME OF OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md.		15b. COUNTY Montg.		15c. CITY OR TOWN Brinklow		
16. FATHER'S NAME FIRST MIDDLE LAST Augusta Holland		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christie Green		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		20. SOCIAL SECURITY NO. 218-38-9207		21. INFORMANT ADDRESS Adelaide Jones (Daughter) same as #13		
22. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INSUFFICIENCY 4370 DUE TO, OR AS A CONSEQUENCE OF CEREBROVASC. SCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last. CHRONIC DUE TO, OR AS A CONSEQUENCE OF ARTERIO SCLEROTIC VASO DIS. YRS				23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ROUTE 1		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ORGANIC BR. SYNDROME. PAGETS DIS. OF BOKE						
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
30. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE		
33. I certify that (a) this hospital attended the deceased from 6/5 , 19 79 , to 6/5 , 19 79 , that (b) (two) last saw the deceased alive on 6/4 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (was) (did) (did not) view the body after death.						
34. SIGNATURE Donald P. Lewis				35. DATE SIGNED 6/5/79		
36. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald Lewis				37. ADDRESS 18111 Prince Philip Dr., Olney, Md.		
38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		39. DATE 6-11-79		40. NAME OF CEMETERY OR CREMATORY Mutual Cemetery		
41. FUNERAL DIRECTOR NAME George R. Snowden		42. ADDRESS 246 N. Washington St. Rockville, Md. 20850		43. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montgomery Md.		
44. BY REG. NO. 25b. REGISTRAR'S SIGNATURE JUN 11 1979						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 2 2 1 4

Female	Black	Oct. 25, 1906	65	18708 New Hampshire Ave.
Male	U.S.A.	1906	18708 New Hampshire Ave.	
Female	Black	Oct. 25, 1906	18708 New Hampshire Ave.	
Male	U.S.A.	1906	18708 New Hampshire Ave.	

Augusta Holland
Christie Green
218-38-9507 Adeline Jones (daughter) same as 410

Christie Green
Adeline Jones (daughter) same as 410
Augusta Holland

Christie Green
Adeline Jones (daughter) same as 410
Augusta Holland

George E. Snowden
245 H. Washington St.
Burlington, N.H. 05401
6-11-70
Burlington Cemetery
Sandy Bottom, N.H.
10111 Tenth Street, N.H.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
CLOYD EDWARD FOXALL			Jun 29 79			M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		
Male		Negro		Jan 15 12		67		MONTHS DAYS HOURS AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Tenn		USA				Mont. MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Md		1401 Blair Mills Road				Teacher		None		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md			MONT		Silver Spring		NO <input type="checkbox"/>		1401 Blair Mill Rd. #420	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Wesley Foxall					Nola Goodall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Unk			414-09-7527		Durilla K. Foxall/wife/same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Transitional Cell Carcinoma left</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>kidney</u>										
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) <u>Metastases to lungs & bone</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 1/2 months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
22a. INJURY OCCURRED			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					CITY OR TOWN COUNTY STATE					
23. I certify that (I) <u>the hospital</u> attended the deceased from <u>June 26 1979</u> to <u>June 29 1979</u> , that (I) <u>saw</u> the deceased alive on <u>June 26 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (did not) view the body after death.										
24. SIGNATURE					25. DEGREE		26. DATE SIGNED			
<u>J. Blaine Duggins</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/29/79			
27a. PHYSICIAN'S NAME (TYPE OR PRINT)					27b. ADDRESS					
28a. BURIAL, CREMATION, REMOVAL (SPECIFY)			28b. DATE		28c. NAME OF CEMETERY OR CREMATORY		28d. LOCATION			
Burial			7-3-79		Ft. Lincoln		Brentwood, Md.			
29. FUNERAL DIRECTOR					30. DATE RECEIVED BY REGISTRAR					
NAME ADDRESS					REGISTRAR'S SIGNATURE					
John T. Rhines Co., 3015 12th St., N.E., D.C.					JUL 8 1979					

1 2 3 4 5 6 7 8 9 10 11 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15216

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) EVELYN BROWN FRANCHERE			2a DATE OF DEATH MONTH DAY YEAR June 30, 1979			2b HOUR 4:30 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 21, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11001 Candlelight Lane				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Potomac		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 11001 Candlelight Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Owans Brown				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna -- Goss					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17 INFORMANT ADDRESS James Aven-Address same as #13.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular collapse 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 5 days years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from July 19 76 to June 30 19 79 , that (1) (we) lost June 26 19 79 (and that in my) (our) opinion death occurred on the date and hour and from the causes stated above, (2) (we) (did) (did not) view the body after death.									
22b SIGNATURE Walter R. Efron MD				22c DATE SIGNED 6/30/79				22d PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Efron	
22e ADDRESS 1125 Rockville Pike, Rockville MD				22f PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Efron		22g ADDRESS 1125 Rockville Pike, Rockville MD		22h DATE REC'D. BY REGISTRAR JUL 6 1979	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE July 2, 1979		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crem.		23d LOCATION CITY OR TOWN COUNTY STATE Suitland-Prince Geo. - Md		23e DECEASED'S SIGNATURE Walter R. Efron	
24 FUNERAL DIRECTOR NAME Chambers Funeral Home-Silver Spring Md.				24b ADDRESS Silver Spring Md.		24c DATE REC'D. BY REGISTRAR JUL 6 1979		24d DECEASED'S SIGNATURE Walter R. Efron	



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15217

1. DECEASED NAME (TYPE OR PRINT) ERNEST FRANKLIN			2a. DATE OF DEATH MONTH 6 DAY 7 YEAR 79			2b. HOUR 5:20 PM						
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH MAR. DAY 28 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT MD.						
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Montg		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4101 Pylers Mill Rd.		
14. FATHER'S NAME FIRST Pete MIDDLE HALL LAST HALL				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE FRANKLIN LAST FRANKLIN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 101-01-4926		17. INFORMANT ADDRESS Helen Franklin (Wife) Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS AND BLEEDING										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE DAY ONE WEEK 2-3 WEEKS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)												
19a. DATE OF OPERATION 5-14-79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL PAIN				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5-13 19 79 , to 6-7 19 79 , that (I) (we) last saw the deceased alive on 6-7 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Berny J. Kreutz						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-8-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNY J. KREUTZ						22e. ADDRESS 5411 CEDAR LANE BETH. MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-14-79		23c. NAME OF CEMETERY OR CREMATORY Ash. Mem. Cem.			23d. LOCATION CITY OR TOWN Sandy Spring COUNTY Montg STATE Md.				
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, Md.						25a. DATE REC'D. BY REGISTRAR JUN 11 1979			25b. REGISTRAR'S SIGNATURE Berny J. Kreutz			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1 2 3 1 1



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 2 1 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emma M. Frazier			2a. DATE OF DEATH MONTH DAY YEAR 06 01 79			2b. HOUR 12:35A			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montg. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.					13b. CITY OR TOWN Montg.		13c. STREET ADDRESS Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST Willis Snowden					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Chase				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-38-9375A		17. INFORMANT ADDRESS Marshall Bell (Grandson) 13402 Dove St. Silver Sprigg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremic, aortic obstruction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Endometrial carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October, 1975 to 5/31/79 , 19____, that (I) (we) last saw the deceased alive on 5/31/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Millman						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman						22e. ADDRESS 20760 15 E. Deer Park Dr., Gaith., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-5-79		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850			25a. DATE REC'D. BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE Robert Millman	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10:00 7 10 0
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10:00 7 10 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 2 1 9	
FOR 1 - STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST CHARLOTTE		MIDDLE W.		LAST FREBURGER		2a DATE OF DEATH MONTH DAY YEAR 6 24 79		2b HOUR 12 28 PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 12 12		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10 CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SORTER		12b KIND OF BUSINESS OR INDUSTRY U.S. TAG & TICKET			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY A.A.		13c CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 183 DIANA DRIVE, 21122			
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES P. WILLIAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH HARVEY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-20-9325		17 INFORMANT RICHARD W. FREBURGER, 183 DIANA DRIVE,				ADDRESS PASADENA, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>shock lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>S/P Mastectomy</u>											
19a DATE OF OPERATION 6/12/79		19b CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of breast				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11/79</u> , 19 <u>79</u> , to <u>6/24</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/24/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Deborah B Goldberg</u>				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/25/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Deborah B Goldberg</u>				22e ADDRESS <u>1106 Spring St, Silver Spring, Maryland</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 06-27-79		23c NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MD.					
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.,				ADDRESS 21229 4107 WILKENS AVE.		25a DATE REC'D. BY REGISTRAR JUN 25 1979		25b REGISTRAR'S SIGNATURE <u>Kirby Helms</u>			

P 1 2 1 1 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at 1-800-368-1234.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 1 5 2 2 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Sara Friedenbergy				2a. DATE OF DEATH MONTH 6 DAY 10 YEAR 79				2b. HOUR 5:30 PM			
3. SEX F		4. RACE white		5. DATE OF BIRTH MONTH Aug DAY 1 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 1 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Book Keeper		12b. KIND OF BUSINESS OR INDUSTRY & accounting			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 257 Congressional Lane					
14. FATHER'S NAME FIRST Unk. MIDDLE LAST Horowitz				15. MOTHER'S MAIDEN NAME FIRST Unk. MIDDLE LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 		17. INFORMANT ADDRESS Laurel, Md. 20811 Robert Friedenbergy-son 8792 Oxwell Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral valve carcinoma to liver 1539 DUE TO, OR AS A CONSEQUENCE OF (b) adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6M 6M	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fracture of Rt femur present but no contributing											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 P.M. 5 28 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Moved in bed in Cherry Chase Nursing home.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) pathology tx		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 							
22a. I certify that (I) (this hospital) attended the deceased from 6/4 , 19 79 , to 6/10 , 19 79 , that (I) (we) last saw the deceased alive on 6/10 , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harvey Cohen				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY M COHEN MD				22e. ADDRESS 1400 SPRING ST SS MD 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-12-79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory				23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY STATE 			
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002 ADDRESS 				25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady					

Lee Funeral Home 300-4th St. N.E. Wash. D.C.

6-12-79

Lee's Crematory

Washington, D.C.

No

Unk

Horrowitz

Unk

Mr.

Rockville

x

257 Congressional Lane

Holy Cross Hospital

Ret. Bookkeeper & accountant

Russia

USA

x

white

Aug 1, 1900

78

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 2 2 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Wanda U Gagliano				2a. DATE OF DEATH 6 13 79		2b. HOUR 9:30 AM			
3 SEX F		4 RACE White		5 DATE OF BIRTH 8 18 20		6 AGE (IN YEARS LAST BIRTHDAY) 58		7 IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Res. Manager		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS 2376 Glenmont Circle	
14. FATHER'S NAME Charles R. Williams				15. MOTHER'S MAIDEN NAME Estalee ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-44-2460		17 INFORMANT Jeffrey R. Gagliano, Son					
				ADDRESS 9018 Abilene Place Clinton, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 5 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Feb 19 79 to 6/13 19 79, that (I) (we) lost saw the deceased alive on 6/13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. Leonard Veld, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-14-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland, P.G., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Robt E Wilhelm ADDRESS 4308 Suitland Rd., Suitland, Md.				25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Anthony McCready			

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

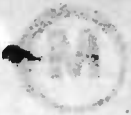
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					79 15222				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MARY MIDDLE M. LAST GALLAHAN					MONTH 6 DAY 26 YEAR 79 2b. HOUR 11 P M				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		CAUC.		MONTH 10 DAY 23 YEAR 07		71		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Cherry Chase Nsg + Conv. Center				RETIRED		CSP Telephone	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Md. P.G. Oxon Hill					13e. STREET ADDRESS				
					913 Shelby DR.				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST JOHN R. GALLAHAN					FIRST MIDDLE LAST GRACE KING				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO None					577-01-2899		FRANCIS GALLAHAN SAME AS ITEM 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
436- DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
						1479 1979 6-26 1979			
22a. I certify that (1) (this hospital) attended the deceased from 6-26 1979, to 6-26 1979, that (1) (we) last saw the deceased alive on 6-26 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE Robert Francis MD						DEGREE		22c. DATE SIGNED	
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
						8630 Fenton St 8.L 816 MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			6/30/79		Resurrection Cem.		CLINTON P.G. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
G.P. KALAS 6160 Oxon Hill Rd. Oxon Hill Md.						JUN 29 1979		Barney McGeedy	

BP

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M. J. Gorman

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH15223
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR							
Michael		G.				Gallo		6/23		19		79				11:00							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR							
Male	Caucasian	1/10/1888		91		YRS.				6/23/79		19		11:00		PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD							
Italy		U.S.A						Montgomery															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Olney		Montgomery General Hospital		Master Steamfitter																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1 Drake Court															
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST													
Giuseppe		Gallo				Josefina		Salvino															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
Yes		WWI		216-03-0588		Isabel J. Phillips, same as #13																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) acute myocardial disease																							
4291																							
DUE TO, OR AS A CONSEQUENCE OF																							
(b) chronic myocardial disease																years							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
NONE																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
NONE														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED															
John S. Rogers, M.D.				Deputy				6/23/79															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
John S. Rogers, M.D.				1919 Seminary Road																			
Silver Spring, Maryland																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Burial				6/26/79				Loudon Park Cemetery				Baltimore, Maryland											
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Robert A. Pumphrey				JUN 28 1979				L. H. Cuddy															
7557 Wisconsin Ave., Bethesda, MD																							



1 2 2 2 3

NAME: Montgomery, Robert
ADDRESS: 111-03-6388, 111-03-6388, 111-03-6388
CITY: New York
STATE: New York
COUNTRY: New York
YES
NO

acute myocardial disease
chronic myocardial disease

NO
NO

John S. Rogers, J.D.
1919 Seminary Road
Silver Spring, Maryland
012579
012579

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15224

FOR 1-STATE REGISTRAR		STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH				15224 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Lawrence V. Gallogly						2a. DATE KNOWN OF DEATH ESTIMATED June 10, 1979				2b. HOUR OF DEATH 7:23	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1958		6. AGE (IN YEARS) (LAST BIRTHDAY) 21 YRS.		7c. DATE PRONOUNCED DEAD June 10, 1979		7d. MONTH OF DEATH 6	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH D. D. Spg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Pub. Sch's	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN D. D. Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11618 College View Dr			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Joseph Gallogly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Mary Albert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Ret. 9/16/60 398-05-2740		17. INFORMANT ADDRESS Helen M. Gallogly, Wife SAA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Div. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Div. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers						TITLE (SPECIFY) Doc		MEDICAL EXAMINER		DATE SIGNED June 10, 1979	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers						ADDRESS 1919 Seminary Road Sil. Spr., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/14/79		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Com.		23d. LOCATION CITY OR TOWN COUNTY STATE Fort Myer, Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS Long & Son 7400 GEORGIA AVE NW WASH DC						25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Patricia McBrady			

1 2 2 2 4

California

Lawrence

U. S. A.

Washington

Teacher

Pub. Sch.

Miss Mary Lister

Miss of Church Delivery

344

John W. Bellows, M.D.

338-02-2740

Ref. 9/18/50

Yes

619 Anthony Road, S.W., Wash., D.C.

John F. Board

Fort Lee, Virginia

Arlington Hall, Com.

6/14/50

Initial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. 1 5 2 2 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>JULIET</u> MIDDLE <u>G.</u> LAST <u>Gantz</u>		2r. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
<u>Juliet G. Gantz</u>				<u>6/16/79</u>		<u>7 P.</u> M.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
<u>Female</u>		<u>White</u>		<u>Feb. 1 1898</u>		<u>81</u> YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
<u>Florida</u>		<u>U.S.A.</u>				<u>Montgomery</u> MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
<u>Chevy Chase</u>		<u>14 Farmington Ct.</u>		<u>Postal Clerk (Ret.)</u>		<u>U.S. Senate</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STREET ADDRESS		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
13r. STATE 13b. COUNTY 13c. CITY OR TOWN		<u>Md</u> <u>Montgomery</u> <u>Bethesda</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>7814 Stratford Road</u>			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
<u>Cromwell</u> <u>Gibbons</u>		<u>Bertha</u> <u>Solee</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
<u>No</u>		<u>217-28-1949</u>		<u>Daughter.</u>		<u>Chevy Chase, Md.</u>			
				<u>Mrs Betty Ann Mitchell, 14 Farmington Ct.</u>					
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>								<u>1 hr.</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u>								<u>2 mos.</u>	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		<u>P.M.</u> <u>19</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>5-23</u> 19 <u>79</u> to <u>5-30</u> 19 <u>79</u> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Richard M. Auld</u>		<u>MD</u>				<u>6/16/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>RICHARD M. AULD</u>		<u>809 Vicks Mill Rd. Rockville, Md 20854</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
<u>Cremation</u>		<u>2/19/1979</u>		<u>Cedar Hill Crematory</u>		<u>Suitland, Maryland.</u>			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>JOSEPH CAWLER'S SONS INC.</u>		<u>6133 WISG. AVE., N. W. WASH., D. C. 20010</u>		<u>JUN 19 1979</u>		<u>Richard M. Auld</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 2 2 6	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Virginia L. Gonzalez</i>						7a. DATE OF DEATH MONTH DAY YEAR <i>6-25-1979</i>		7b. HOUR <i>12:34 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-7-1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.		8. UNDER 1 YEAR MONTHS DAYS HOURS MINS			
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N. Carolina</i>		7d. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i> MD.					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Adventist Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Upholstering</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Selfemployed</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>State.</i>		13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>Mt. Rainier</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3434-Rhode Island Ave.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Faison</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Leona Perry</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>Alexander Gonzalez Same As Above</i>							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). (Husband)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Shock</i>											
4560 DUE TO, OR AS A CONSEQUENCE OF (b) <i>blood lps.</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>isophthalic anhydride</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>chronic liver wds</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>29 6/25 19 79</i>		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>29 6/25 19 79</i> to <i>6/25 19 79</i> and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE				22c. DATE SIGNED <i>6/25/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-28-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Geo. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i> ADDRESS <i>Mt. Rainier, Md.</i>				25a. DATE RECEIVED BY REGISTRAR <i>JUL 2 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITALS: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 5 2 2 7 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Gilbert		MIDDLE D.		LAST Garman		2a. DATE OF DEATH MONTH DAY YEAR 6 12 79		2b. HOUR 3 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-26-1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont.				MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. G.P.O.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.					
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6700 - Belcrest Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Jay H. Garman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gay S. Lloyd									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Edna F. Garman (Wife)		ADDRESS Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF COLON 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 79, to JUNE 12 19 79, that (I) (we) last saw the deceased alive on JUNE 12 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE James A. Brown MD		DEGREE		22c. DATE SIGNED 6/12/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN MD		22e. ADDRESS 6700 BELCREST RD HYATTSVILLE MD 20782									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.					
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE L. H. McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 15228 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Phyllis B. George</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>6 17 79</i>				2b. HOUR <i>1:30 P.M.</i>			
3. SEX <i>female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 4 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>57</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Tenn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Montgomery</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Piano Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-Empl.</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Tenn.</i>				13b. COUNTY <i>Sullivan</i>		13c. CITY OR TOWN <i>Kings Port</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1264 Catawba St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert D. Brockman</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Joyce Eckhart</i>				ADDRESS <i>2407 Cherokee St. Adelphi, Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>412 24 2294</i>		17. INFORMANT <i>William Brockman (Nephew)</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ventricular Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Heart Failure</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension (?)</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6/13 19 79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>6/13 19 79</i> to <i>6/17 19 79</i> , that (I) (we) lost saw the deceased (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Boo K. King</i>				22c. DATE SIGNED <i>6/19/79</i>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Boo K. King</i>			
22e. ADDRESS <i>Suburban Hospital, Bethesda, Md.</i>				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/20/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Kingsport Sullivan Tenn.</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Hines/Rinaldi F.H. 11800 New Hamp.Ave. Silver Spring, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Barbara M. ...</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			REG. NO. 9 15229						
1. DECEASED NAME (TYPE OR PRINT) HUGH N. GLENN			2a. DATE OF DEATH MONTH DAY YEAR June 19 1979			2b. HOUR 10:20 P.			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 21 06		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10414 Hayes Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Govt.	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10414 Hayes Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John H. Glenn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Casey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII			17. INFORMANT ADDRESS 579-14-1094			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from 6/9/79 , 19 5/22/79 , to 5/22/79 , 19 5/22/79 , that (I) (we) last saw the deceased alive on 5/22/79 , 19 5/22/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22a. SIGNATURE Richard C. Hoff				DEGREE MD				22c. DATE SIGNED 6/20/79	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) R. C. Hoff, MD				22e. ADDRESS 10620 64 Ave SS Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/20/79		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE Robert A. Cressley	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 2 3 0	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ANNA MAY Goddard						2a. DATE OF DEATH MONTH DAY YEAR 6 1 79		2b. HOUR 1:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH DAY MONTH YEAR July 10 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nurs. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3210 Spartan Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK L. HECKENLIVELY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HASSIE Gertrude (UNKNOWN)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 467-20-1964		17. INFORMANT Robert V. Goddard		ADDRESS Same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: TERMINAL PULMONARY CONGESTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 DPH.											
IMMEDIATE CAUSE (a) 4349 DUE TO, OR AS A CONSEQUENCE OF HYPOTATIL PNEUMONIA TERM.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CELEBRAL INFARCTIONS (ASCVD) 4 WKS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) ASCVD: CONGESTIVE FAILURE: HEMIPARESIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/19 19 77 to 6/1 19 79 that (I) (we) saw the deceased alive on 6/1/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (or) did not see the body after death)											
22b. SIGNATURE Donald R. Lewis DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD				22e. ADDRESS OLNEY, MARYLAND 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 2-1979		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.					
24. FUNERAL DIRECTOR NAME Francis H. Barber ADDRESS Laytonsville Md.				25a. DATE JUN 5 1979		BY REGISTERAR Barbara K. Bundy					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15231
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH										2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		2b. HOUR					
KARL						GOLD BERG		6		2		1979		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR							
Male		CAUC		3 15 29		50 YRS.				6 P		1979		530 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
New York				U.S.A.								MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
ROCKVILLE				731 MONROE ST								MATHEMATICS				PHD			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
MD				MONT				ROCKVILLE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				731 MONROE ST			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST								FIRST MIDDLE LAST											
Louis Goldberg								Eleanore Levenson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No								102-22-3269				Beatrice Goldberg				3801 Connecticut Ave. N.W. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS																			
410- DUE TO, OR AS A CONSEQUENCE OF																			
(b) ARTERIOSCLEROSIS																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) HYPERTENSION																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
DIABETES - ARTHRITIS																			
19a. DATE OF OPERATION																			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																			
70. AUTOPSY?																			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH																			
21b. TIME OF INJURY																			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK																			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																			
21f. LOCATION																			
21g. CITY OR TOWN																			
21h. COUNTY																			
21i. STATE																			
22a. I certify that I took charge of the deceased described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
22b. I certify that I took charge of the deceased described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)																			
23b. DATE																			
23c. NAME OF CEMETERY OR CREMATORY																			
23d. LOCATION																			
23e. CITY OR TOWN																			
23f. COUNTY																			
23g. STATE																			
24. FUNERAL DIRECTOR																			
NAME																			
ADDRESS																			
25a. DATE REC'D. BY REGISTRAR																			
25b. REGISTRAR'S SIGNATURE																			

1001 BP
Cremation 6/10/79 Metropolitan Alexandria Fairfax Va.
Funeral Director: Wheeler Funeral Home 1331 Rockville Pike Rockville, Md.
Date Rec'd. by Registrar: JUN 14 1979
Registrar's Signature: [Signature]

1 2 3 4



105-22-1569
Service Officer
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2
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15232

1. DECEASED NAME (TYPE OR PRINT) ROSE B. GOODMAN			2a. DATE OF DEATH MONTH June DAY 19 YEAR 1979		2b. HOUR 9:40 AM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH MAY DAY 12 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE NSC - CONV. CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY PRINCE GEO. 13c. CITY OR TOWN UPPER MARLBOROUGH			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14 FATHER'S NAME FIRST MOSES MIDDLE - LAST BECKER			15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE - LAST COHEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-40-7286		17. INFORMANT ADDRESS WILLIAM GOODMAN-ADDRESS SAME AS #13 ABOVE.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-19-79 to 6-19-79 , that (I) (we) lost saw the deceased alive on 6-19-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) did not view the body after death.					
22b. SIGNATURE Robert J. Fromer MD				22c. DATE SIGNED 6/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 8630 FENTON ST SILVER SPRING	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 22, 1979		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE SUTTLAND-PRINCE GEO. CO.-MD.		24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME-SILVER SPRING, MD. ADDRESS			
25a. DATE REC'D. BY REGISTRAR JUN 28 1979				25b. REGISTRAR'S SIGNATURE Harvey McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Ida</i>			FIRST MIDDLE LAST <i>GOTTLIEB</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 5 79</i>			2b. HOUR <i>6⁰⁰ A.M.</i>					
3. SEX <i>Female</i>			4. RACE <i>WHITE</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>MARCH 10, 1892</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>POLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>					
13a. STATE <i>MD.</i>			13b. COUNTY <i>Mont.</i>			13c. CITY OR TOWN <i>SILVER SPRING</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>MICHEL MENDELBAUM</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ESTHER KEYSER</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>212-16-9961D</i>					
17. INFORMANT ADDRESS <i>6404 MARJORY LANE, BETHESDA, MARYLAND</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Aortic Aneurysm</i>			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART I OR PART 2)			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that (i) (the hospital) attended the deceased from <i>6/1 1978</i> to <i>6/3 1979</i> , that (i) (the hospital) saw the deceased alive on <i>6/3 1979</i> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (If (you) did not examine the body after death.					
22b. SIGNATURE <i>Ralph E. Seligmann</i>			DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>6/5/79</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RALPH E. SELIGMANN</i>					
22e. ADDRESS <i>8630 FENTON ST. SILVER SPRING, MD 20910</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>6/6/1979</i>			23c. NAME OF CEMETERY OR CREMATORY <i>BETH SHOLOM CONGREGATION CEMETERY</i>					
23d. LOCATION CITY OR TOWN COUNTY STATE <i>HILLSIDE PR. GEO. MD.</i>			24. FUNERAL DIRECTOR NAME <i>DONALD M. STEIN</i>			24b. ADDRESS <i>232 CARROLL STREET, N.W., WASHINGTON, D. C.</i>			25a. DATE REC'D. BY REGISTRAR <i>JUN 8 1979</i>					
25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>			26. EXAMINER'S SIGNATURE <i>Dr. Rogers</i>			26b. ADDRESS <i>6404 MARJORY LANE, BETHESDA, MARYLAND</i>			26c. DATE <i>6/5/79</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared Medical Examiner - Dr. Rogers

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15234

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Catherine L. Graham</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6-28-79</i>			2b. HOUR <i>6:45 AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Mar. 10 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Acacia Realty Co.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2024 Glen Ross Road,</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry Lapish</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth Yestingsmeier</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>577-03-4697</i>		17. INFORMANT ADDRESS <i>Daniel P. Graham-husband-(same as 13e)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, breast</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 mo</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1970</i> to <i>6-28</i> 19 <i>79</i> , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on <i>6-27</i> 19 <i>79</i> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/>) (<input type="checkbox"/>) did not view the body after death.									
22b. SIGNATURE <i>G. Sengstack md.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6-28-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Sengstack, MD.</i>				22e. ADDRESS <i>9241 Columbia Blvd., S.S. Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7-2-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, DC</i>			
24. FUNERAL DIRECTOR <i>Walter E. Pumphrey, Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>			
24b. ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
Cornel Gray		June 13, 1979		4:35 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	83	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Czechoslovakia	USA	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION (THE MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Lakeaton	Randolph Niles Nursing Home	Retired	Self Employed Bead Importer		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	DeVan		
Md Montgomery Silver Spring		12516 DeVan Drive			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)			
Leopold Gray	Erel (Unknown)	16b. SOCIAL SECURITY NO. 17. INFORMANT			
Yes Austrian WWII		117-28-2940		Dr. Gray	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF PROSTATE		7 years			
185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/2, 1979, to 6/3, 1979, that (2) (we) last saw the deceased alive on 6/3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we did not view the body after death).					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Martin C. Shargel		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
MARTIN C. SHARGEL, M.D.		3720 FARLACUT AVE. KENSINGTON, MD - 20795			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	6/15/79	Mt. Hebron Cemetery		Flushing, New York	
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc.	JUN 18 1979		D. J. Brady		

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR										
Blair Purcell Green								6 27 1979								9:30 a.										
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR										
male	black	Oct. 16, 1963		15 YRS.						6 28 1979																
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																				
Wash. D. C.		U.S.A.		Montgomery County MD.																						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)																								
Silver Springs		200 Blk Lamberton Drive/Wooded area Student																								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																		
Md.		Montg.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		307 Charlton Court																		
14. FATHER'S NAME									15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST									FIRST MIDDLE LAST																	
Penrose W. Green III									Crystal Hollins																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)									16b. SOCIAL SECURITY NO.									17. INFORMANT ADDRESS								
No																		Penrose W. Green III (father) Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																										
PART I DEATH WAS CAUSED BY:																										
IMMEDIATE CAUSE (a) <u>Gun shot wound to head</u>																										
9854																										
DUE TO, OR AS A CONSEQUENCE OF																										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																										
(b) _____																										
DUE TO, OR AS A CONSEQUENCE OF																										
(c) _____																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?														
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR AM. MONTH, DAY, YEAR P.M. 6/27/1979						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
						shot in head																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION														
						wooded area						200 Blk Lamberton Dr. Silver Spring Montg. Md.														
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																										
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED														
<i>JRG</i>						Assistant						6/28/79														
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																				
Hormez R. Guard, M.D.						111 Penn Street, Baltimore, MD 21201																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION								
Cremation						7-3-79						Lee's Crematorium						Washington, D. C.								
24. FUNERAL DIRECTOR NAME						24b. ADDRESS						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE								
George R. Snowden						246 N. Washington Street Rockville, Md. 20850						JUL 5 1979						<i>Robert M. Brady</i>								

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
1VR A15 ME (5)
15M 7/76

1 2 2 3 6

Oct. 16, 1963 12

U.S.A.

307 Charlton Court

21401 Spring

Crystal Springs

George W. Green III

George W. Green III (Father)

Lee's Corporation

7-3-70

Washington

246 N. Washington Street
Rockville, Md. 20850

George W. Green

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMM-16 20M
(VRA 15, 4) 7/78

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15237

1 DECEASED NAME (TYPE OR PRINT) Bessie J. Grohs			2a DATE OF DEATH MONTH DAY YEAR 6-9-79			7b HOUR 9:30 AM				
3 SEX Female		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 6-16-04		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., D. C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 309 INDIAN SPRING DRIVE	
14 FATHER'S NAME FIRST MIDDLE LAST IRVIN E. JONES			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY LICKNER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-2978		17 INFORMANT ADDRESS LOUIS H. GROHS SAME AS 13 HUSBAND						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest sec. to cerebral bleeding 431- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from June 1978 , to 6/9 , 19 79 , that (I) (we) lost spw the deceased alive on 6/9/79 , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Smith Ho MD				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/9/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) SMITH HO MD				22e ADDRESS 8323 Haddon Dr. Takoma PK md. 20012						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 6/12/79		23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.				
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a DATE REC'D. BY REGISTRAR JUN 12 1979		25b REGISTRAR'S SIGNATURE Francis J. Collins				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		7 9 1 5 2 3 8		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Morris		S.		Gurin		Gurin		6/22/79		5 P M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
Male		Caucasian		June 10, 1890		89 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia/Poland		U.S.A.				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Chevy Chase Nursing Center				Pharmacist		Pharmacy			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring				413 Hillmoor Drive			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Jacob Gurin		Bertha Friedlander									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		084-05-1677		Jacob Gurin, Son		Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma prostate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma prostate</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
		Prostate carcinoma									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> 19 <u>79</u> , to <u>present</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
John B. Umhan MD		MD				6/22/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
John B. Umhan MD		8805 Conn. Ave. Chevy Chase MD 20015									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Removal		June 22, 1979		George Washington Medical School		Washington, D.C.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Capitol Funeral Service		Fairfax, Virginia		JUN 26 1979		L. J. McCreedy					

8 3 3 1 2 3 8



June 10, 1940

University of California

Department of Chemistry

San Francisco, California

Dear Sir:

I am writing to you regarding the

matter of the

report of the

committee on

the subject of

the proposed

amendment to

the constitution

of the

University of California

and the

Board of Regents



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		7 9		1 5 2 3 9		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
MARION FLORENCE HAMMERLUND				6-7-79		1 P M			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		CAUCASIAN		3-4-1886		93 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
ILLINOIS		U.S.A.				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		ALTHEA WOODLAND		HOUSEWIFE		HOME			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD.		MONT. Silver Spring				10117 Big Rock Road.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Frank M. SIMPSON		Marion Tanner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		577-03-4993		DON HAMMERLUND (Son) 10117 BIG ROCK RD. S.S. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Cardiac Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary atherosclerosis								?	
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 74 to 7 June 19 79, that (I) (we) lost saw the deceased alive on 5 June 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
William D. Aud, M.D.						7 June '79			
22d. PHYSICIAN'S NAME		22e. ADDRESS							
		9006 Colesville d., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMC /AL (SPECIFY)		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Rock Creek Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH GAWLER'S SONS INC.		6/9/1979		13/19		History McCreedy			
5130 WISB. AVE., N. W. WASH., D. C. 20014									

9 2 2 2 1 2

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



(no)

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
OFFICE OF THE ASSISTANT ATTORNEY GENERAL
WASHINGTON, D. C.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15240

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Uera Lorraine Handey		2a. DATE KNOWN OF DEATH ESTIMATED June 11, 1979		2b. HOUR 1:25 PM
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR May 20, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7c. DATE PRONOUNCED DEAD June 11, 1979
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Sil. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10000 Brunswick Ave Apt 112		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
13a. STATE Md		13b. CITY OR TOWN Sil. Spg		13c. STREET ADDRESS 10000 Brunswick Ave Apt 112
14. FATHER'S NAME FIRST MIDDLE LAST Charles Stoggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Allie Baumgarner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 574-05-8602		17. INFORMANT ADDRESS 2309 N. Gate Terr. S. S., Md. 20906
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4291 Acute Myocardial Inf.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b)				
DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep		DATE SIGNED June 11, 1979
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers		ADDRESS Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Sam Houston Nat'l. Cem. San Antonio, Texas
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Dorothy K. Cuddy

[Faint, mostly illegible handwritten text at the top of the page, possibly including a name and address.]

[Faint, mostly illegible handwritten text in the middle section, possibly a date and location.]

[Faint, mostly illegible handwritten text in the lower middle section, possibly a signature or name.]

[Faint, mostly illegible handwritten text at the bottom of the page, possibly a date and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 9 15241									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Claire		MIDDLE M.		LAST Haraway		2a. DATE OF DEATH MONTH DAY YEAR 06-13-79		2b. HOUR 11 ⁰⁰ AM	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12508 Village Square Ter.			
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Mahan				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katharine (Unknown)				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 579-09-4390				17 INFORMANT 9715 Holmhurst Rd. Sandra M. Ricketts Bethesda, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours days	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from August 1977, to June 13, 1979, that (I) (we) last saw the deceased alive on June 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.											
22b. SIGNATURE Harris Kenner				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED June 13, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harris Kenner				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 16, 1979		23c. NAME OF CEMETERY OR CREMATORY Sh erwood Burial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Salem, Va.					
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.				25a. DATE RECEIVED JUN 19 1979		25b. SIGNATURE [Signature]					

1 4 5 2 1 8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 1 5 2 4 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST GEORGE		MIDDLE EARL		LAST HARRIS		2a. DATE OF DEATH MONTH 6 DAY 17 YEAR 1979	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 5 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85		7b. HOUR 10⁴ AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.H.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7908 Cyprus Pl.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Business Systems	
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7908 Cyprus Pl.	
14. FATHER'S NAME FIRST James MIDDLE LAST Harris		15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE LAST Shattuck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT Virginia Harris, Wife.		ADDRESS Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1889 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Bladder DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Carcinoma of prostate. Chronic leukemia									
19a. DATE OF OPERATION 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/13 19 77 , to passed 19 , the (I) (we) last saw the deceased alive on 6/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Umbauer		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umbauer		22e. ADDRESS 8805 Conn. Ave. Chevy Chase, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/18/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION COUNTY Suitland, Maryland STATE Md			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC.		ADDRESS 5130 WISD. AVE., N. W. WASH., D. C. 20016		25a. DATE RECEIVED BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

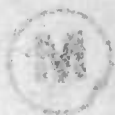
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				15243 REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Violetmae		MIDDLE Crystal		LAST Hastey		2b. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> 6/13 1979		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 6/13 1979		2d. HOUR		M 6:00																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION		13. KIND OF BUSINESS OR INDUSTRY															
Female		White		May 25, 1908		71 YRS.		MONTHS		DAYS		HOURS		MIN.		Montgomery County		Chevy Chase		2621 East West Highway		Asst. Librarian		state Comm.											
7a. BIRTHPLACE		(STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION		13. KIND OF BUSINESS OR INDUSTRY		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS					
Illinois		U.S.A.																																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. AUTOPSY?		21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED?		23. HOW INJURY OCCURRED		24. LOCATION					
Maryland		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input type="checkbox"/>		2621 East West Highway		Laverne		Ellen		No		220-48-2694		George Hastey Husband.		Same as item 13.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None		None		None		None					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. AUTOPSY?		21. DATE OF OPERATION		22. CONDITION FOR WHICH OPERATION WAS PERFORMED?		23. HOW INJURY OCCURRED		24. LOCATION		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		27. NAME		28. ADDRESS		29. DATE REC'D. BY REGISTRAR		30. REGISTRAR'S SIGNATURE			
Laverne		Ellen		No		220-48-2694		George Hastey Husband.		Same as item 13.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None		None		None		None		JUN 18 1979		Hastey		JOSEPH GAWLER'S SONS INC.		519 WISSE AVE., N. W. WASH., D. C. 20016		JUN 18 1979		Hastey			
18. CAUSE OF DEATH		19. IMMEDIATE CAUSE		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		22. DUE TO, OR AS A CONSEQUENCE OF		23. DUE TO, OR AS A CONSEQUENCE OF		24. DUE TO, OR AS A CONSEQUENCE OF		25. DUE TO, OR AS A CONSEQUENCE OF		26. DUE TO, OR AS A CONSEQUENCE OF		27. DUE TO, OR AS A CONSEQUENCE OF		28. DUE TO, OR AS A CONSEQUENCE OF		29. DUE TO, OR AS A CONSEQUENCE OF		30. DUE TO, OR AS A CONSEQUENCE OF		31. DUE TO, OR AS A CONSEQUENCE OF		32. DUE TO, OR AS A CONSEQUENCE OF		33. DUE TO, OR AS A CONSEQUENCE OF		34. DUE TO, OR AS A CONSEQUENCE OF			
4291		Acute myocardial disease.																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None																																	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22a. I certify that I took charge of the remains described above, held an		22b. Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		22c. death resulted from:		22d. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22e. TITLE (SPECIFY)		22f. DATE SIGNED		22g. EXAMINER'S NAME		22h. ADDRESS		22i. NAME		22j. ADDRESS		22k. DATE REC'D. BY REGISTRAR		22l. REGISTRAR'S SIGNATURE	
None		19		None		None		None		None		None		None		None		None		Deputy		6/13/79		John S. Rogers, M.D.		1919 Seminary Road		Silver Spring, Montgomery, Md.		None		None		None	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE		24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		27. NAME		28. ADDRESS		29. DATE REC'D. BY REGISTRAR		30. REGISTRAR'S SIGNATURE		31. NAME		32. ADDRESS		33. DATE REC'D. BY REGISTRAR		34. REGISTRAR'S SIGNATURE			
Removal		6/15/1979		Montlawn Cemetery		Raleigh		N.C.		None		JOSEPH GAWLER'S SONS INC.		JUN 18 1979		Hastey		JOSEPH GAWLER'S SONS INC.		519 WISSE AVE., N. W. WASH., D. C. 20016		JUN 18 1979		Hastey		JOSEPH GAWLER'S SONS INC.		519 WISSE AVE., N. W. WASH., D. C. 20016		JUN 18 1979		Hastey			

12243

Very truly yours,
[Signature]



U. S. DEPARTMENT OF THE INTERIOR

Division of Reclamation

Washington, D. C.

Division of Reclamation

Division of Reclamation

Division of Reclamation

Division of Reclamation

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1902

Division of Reclamation

Division of Reclamation

Division of Reclamation

TO HOSPITAL: EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15244			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES EARL HAWKINS				6 7 1979			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8 1914		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7900 Custer Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Committeeman (Ret)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Congress	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Hawkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Anable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 493-05-5694		17. INFORMANT ADDRESS Colette E Hawkins, Wife. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) was did not attend the deceased from OCT 21 , 19 74 , to JUNE 6 , 19 79 , that (I) was did not see the deceased alive on JUNE 6 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.							
22b. SIGNATURE Fred A. Gill				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred A. Gill				22e. ADDRESS 4743 Bradley Blvd., Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/9/1979		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.	
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC.				25a. DATE JUN 12 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy	
5138 WISC. AVE., N. W. WASH., D. C. 20016							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 2 4 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MURRAY		MIDDLE ADAMS		LAST HAWKINS		2a. DATE OF DEATH MONTH DAY YEAR 6 3 79	
3 SEX Female		RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 7 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dress Fitter		12b. KIND OF BUSINESS OR INDUSTRY Dress Shop			
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4811 Eades St	
14. FATHER'S NAME FIRST Henry MIDDLE L. LAST Adams		15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE J. LAST Lowe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-09-8134		17. INFORMANT ADDRESS Murray A Hawkins, Son. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSEPTIC HEART DISEASE								5 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture Right Hip									
19a. DATE OF OPERATION May 1, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Right Hip				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. 4 18 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Took Fall in Home					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4811 Eades St. Rockville Mont. Md					
22a. I certify that (b) (this hospital) attended the deceased from 4/20 19 79, to 6/3 19 79, that (b) (we) lost saw the deceased alive on 5/29 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE Michael R. Dobridge		DEGREE M.D.		22c. DATE SIGNED June 3, 1979					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael R. Dobridge		22e. ADDRESS 13975 Connecticut Ave Silver Spring Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/1979		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC. ADDRESS 6130 WISC. AVE., N. W. WASH., D. C. 20016		25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Patrick McCreedy					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR				7 9 1 5 2 4 6				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Celestia B. HAYES				2a. DATE OF DEATH MONTH 6 DAY 15 YEAR 79				2b. HOUR 3:59 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH June DAY 14 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Dan MIDDLE - LAST Bradford				15. MOTHER'S MAIDEN NAME FIRST Rosa MIDDLE - LAST Cains					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO 417-54-2915		17. INFORMANT ADDRESS T. Price Same as # 13			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of rectum 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) liver metastasis. Rectovaginal fistula & perineal abscess.									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 14 June 1979 to 15 June 1979 , that (I) (we) last saw the deceased alive on 14 June 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Donald E. Dillon MD				DEGREE MD				22c. DATE SIGNED 15 June 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, Md.				22e. ADDRESS Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal				23b. DATE June 15, 1979		23c. NAME OF CEMETERY OR CREMATORY Grace Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Birmingham Jefferson Alabama	
24. FUNERAL DIRECTOR FRANCIS H. BARBER				24b. ADDRESS LAYTONSVILLE, MD. 20760		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Gandy	

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **15247**

1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST James, Joseph Hayes									
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 1/25/10		6. AGE (IN YEARS) (LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE OF DEATH ESTIMATED MONTH DAY YEAR 8-8-79		2b. HOUR OF DEATH 8:00p
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE ELECTO-TYPE			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1106 KIRKLYNN AVE.			
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL HAYES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DONOVAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 018-10-5528		17. INFORMANT ADDRESS MARIE E. HAYES 1106 KIRKLYNN AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma & Brain Contusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Extensive Skull Fracture DUE TO, OR AS A CONSEQUENCE OF (c) trauma fall											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Alcoholism											
19a. DATE OF OPERATION 6-7-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left Subdural Hematoma & Left Temporal Contusion				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 6:45 P.M. 6-7-79				21b. TIME OF INJURY HOURS MIN. MONTH DAY YEAR 6:45 P.M. 6-7-79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell down stairs at home			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1106 Kirklynn Ave Takoma Park PG MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Richard S. Whelton				TITLE (SPECIFY) Deputy				DATE SIGNED 6-8-79			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON				ADDRESS 7100 Balt. Ave College Park Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE June 12, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD		
24. FUNERAL DIRECTOR NAME TAKOMA F.H., Inc.				ADDRESS 254 CARROLL ST. N.W. Wash., D.C. 20012				DATE REC'D. BY REGISTRAR JUN 12 1979		REGISTRAR'S SIGNATURE Anthony M. Brady	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15248

1. DECEASED NAME (TYPE OR PRINT) Helen F. Helm			2a. DATE OF DEATH MONTH DAY YEAR 6 11 79			2b. HOUR 9:50 A M					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10 15 97		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10201 Grosvenor Place		
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Hohman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 487-50-7660	
17. INFORMANT Harry A. Helm			7912 Greentree Rd. Bethesda, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>1629</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
19a. DATE OF OPERATION May 79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Lung Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>several years</u> 19 <u>77</u> to <u>79</u> , that (I) (we) saw the deceased alive on <u>6/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								22b. SIGNATURE James W. Egan M.D.		22c. DATE SIGNED 6/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Egan				22e. ADDRESS 5413 Cedar Ln. - Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 14, 79		23c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE St. Louis, Mo.					
24. FUNERAL DIRECTOR NAME R Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE P. J. McCready					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.



1 2 3 4 8

Missouri
Berthel
Mont. 10201 Grosvenor Place
Bethesda, Md.
487-50-7000 Harry A. Helm
7012 Grosvenor Rd.
Bethesda, Md.

Robert A. Helm
June 14, 1960
St. Louis, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Mayle released the body to Dr. Fitzgerald

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. DECEASED NAME (TYPE OR PRINT) Patrick Henry					2a. DATE OF DEATH MONTH DAY YEAR June 1, 1979					2b. HOUR 4:20 PM				
3 SEX Male			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12/26/1924			6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS			IF UNDER 1 YEAR MONTHS DAYS 54		IF UNDER 24 HRS HOURS MIN 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.			7b. CITIZEN OF WHAT COUNTRY? White			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Retail		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6015 Henning St.			
14 FATHER'S NAME FIRST MIDDLE LAST Lyle Patrick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby Ladson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 579-20-0554		17 INFORMANT ADDRESS Patricia V. Henry, Wife. Same as item 13.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5 yr										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that W.H. Mayle attended the deceased from June 1, 1975 to June 1, 1979 , that he last saw the deceased alive on June 1, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. W.H. Mayle (did not) view the body after death.														
22b. SIGNATURE W.H. Mayle M.D.										DEGREE M.D.		22c. DATE SIGNED June 1, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. Fitzgerald										22e. ADDRESS 8218 Wisc. Ave., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/5/1979		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.				
24 FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. ADDRESS 5130 WISD. AVE., N. W. WASH., D. C. 20016										25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Patrick McCready		

BP



Index

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15250

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louis Israel Herskowitz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6/4/1979</i>			2b. HOUR MIN <i>2:14 P</i>	
3. SEX <i>Male</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 09 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Austria</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MANAGER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AUTO PARTS</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>Silver Spring</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Isaac Herskowitz</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Pachter</i>		16. ADDRESS <i>7740 ANNAPOLIS ROCK RD.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>171-05-0439</i>		17. INFORMANT <i>JEROME HERSKOWITZ, SON-Gaithersburg, Md.</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable ventricular rupture</i> 410- DUE TO, OR AS A CONSEQUENCE OF <i>myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Days</i> DUE TO, OR AS A CONSEQUENCE OF <i>Coronary artery disease</i> <i>Years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Hypertension</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/31/79 7 P.M.</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>7600 Carroll Avenue Falls Church VIRGINIA</i>			
22a. I certify that (1) this hospital attended the deceased from <i>5/31/79</i> to <i>6/4/79</i> that (2) I last saw the deceased alive on <i>5/31/79</i> and that in my (our) opinion death occurred on the date and hour (and from the causes stated above) (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Samuel</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5/9/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PAMUEL DICKOZZE</i>		22e. ADDRESS <i>7600 Carroll Avenue</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6/6/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>KING DAVID MEMORIAL GARDEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>FALLS CHURCH VIRGINIA</i>	
24. FUNERAL DIRECTOR NAME <i>DONALD M. STEIN</i> ADDRESS <i>HEBREW MEMORIAL F.H. 232 CARROLL STREET, N.W., WASHINGTON, D. C.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1979</i>			
				25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

0 2 2 1 1 1 1

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

15251

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Vivian J. Heston			2a DATE OF DEATH MONTH 6 DAY 1 YEAR 79			2b HOUR 2:55 AM			
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH 4 DAY 12 YEAR 08		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS 7 DAYS 15	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10504 Montrose Ave. #104				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor		12b KIND OF BUSINESS OR INDUSTRY Cancer Institute	
13a STATE Md.			13b COUNTY Montg.		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST Ray MIDDLE Janney LAST Gertrude			15 MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE Kitzmiller LAST Kitzmiller			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. 216-44-6907			17 INFORMANT David J. Heston			18 ADDRESS 11503 Notch Cliff Rd. Glen Arm, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrahepatic Biliary Obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Melastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/4 19 79 , to 6/1 19 79 , that (I) (we) last saw the deceased alive on 5/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)									
22b. SIGNATURE Stephen J. Newman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman			22e. ADDRESS 5411 Cedar Lane Bethesda						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 2, 1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN Alexandria COUNTY Va. STATE		
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Home, P.A. Bethesda, Md.			25a. DATE REC'D. BY REGISTRAR JUN 6 1979			25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RAY
JANNEY
GORTLAND
11505 North Cliff Rd.
Alexandria, Va.
210-44-607 David J. Larson
10204 Montrose Rd. #104
Bethesda
X
10204 Montrose Rd. #104
Editor
Larson
USA
X
Montgomery

Honor. A.A.
Robert A. Humphrey Funeral
June 2, 1972
Alexandria, Va.
210-44-607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15252

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MRS. CLADYS I. W. HEUENER		2a. DATE OF DEATH MONTH DAY YEAR 6-16-79	
3. SEX F	4. RACE W	2b. HOUR 8:22 AM	
5. DATE OF BIRTH MONTH DAY YEAR 11 17 02		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va		7b. CITIZEN OF WHAT COUNTRY? U.S.	
8. CITY OR TOWN OF DEATH SILVER SPRING		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		11. USUAL OCCUPATION (INDICATE IF MOST OF WORKING LIFE) Retired	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.		13. STREET ADDRESS 6609-5th St. NW	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wolfe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Rapke	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-32-9819	
17. INFORMANT ADDRESS Dennis X. Heuener		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure 486- DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET		21f. CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from June 15, 1979, to June 15, 1979, that (I) (we) last saw the deceased alive on June 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE Dennis X. Heuener		22b. DATE SIGNED 6/16/79	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) D. HOWARD GOLDSKIN		22d. ADDRESS 4701 Randolph Rd, Rockville	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 19-1979	
23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Arthur Walters		25a. DATE REC'D. BY REGISTRAR JUN 19 1979	
25b. REGISTRAR'S SIGNATURE Anthony A. Brady			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15253

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Hilgenberg			2a. DATE OF DEATH MONTH DAY YEAR 6 20 79			2b. HOUR 1:40	
3. SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 20, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 12815 CALDWELL STREET		14 FATHER'S NAME FIRST MIDDLE LAST STESL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-16-253		17 INFORMANT SON EDWARD P. HILGENBERG		ADDRESS 100 TAMARISK COURT GREENBELT, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 410- DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YRS YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HEPATITIS - TIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 60, to 6/20 79, that (I) (we) last saw the deceased alive on 6/18 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard P. Delaney MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY MD		22e. ADDRESS 4323 HAVARD ST SIL SPR, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/23/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE P. J. Delaney	
500 UNIV BLVD. W. SILVER SPRING, MD. 20901							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 1 5 2 5 4 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Doyle RAYMOND Hilley						06 02 79			1:57P M
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		09 03 08			70 YRS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Georgia		USA					Montgomery MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital			Electrician(ret)				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN			13b. STREET ADDRESS			
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
MD			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
DOZIER A. HILLEY			LOUISE M. SANDERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS			
YES			WW II			SHIRLEY E. HILLEY SAME AS 13 WIFE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cornary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lung Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28/79</u> 19 <u>79</u> to <u>6/2/79</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/2/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			22c. DATE SIGNED			
<u>Julius Cioffi</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/3/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
R. CIOFFI			10620 Ga. Ave. SS, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			6/6/79		ARLINGTON NATIONAL		ARLINGTON VIRGINIA		
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS 500 UNIV. BLVD., W.; SILVER SPRING, MD. 20901			JUN 5 1979			<u>John H. Huddy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 5 2 5 5	
FOR 1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Woodrow Hoes			2a. DATE OF DEATH MONTH DAY YEAR 6-22-79		2b. HOUR 2:30 P.M.
3. SEX m	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8-22-16	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FAN. TOR	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Montg	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Hoes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia Corn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-12-2155	17. INFORMANT ADDRESS Pauline Hoes - SAME AS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5715 HEMATEMESES DUE TO, OR AS A CONSEQUENCE OF (b) ESOPHAGEAL VARICES + PORTAL CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 6-22-79, to 6-22-79, that (2) (the) last view the body after death.					
22b. SIGNATURE Robert J. Lindeman		DEGREE M.D.		22c. DATE SIGNED 6/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Lindeman		22e. ADDRESS M.P. 0215 Fernwood Rd, Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-27-79	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Germantown Montg Md.
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Wash. St. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 26 1979	

1 2 2 2 2



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15256

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Holland Irene Cooper Holland</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6/4/79</i>			2b. HOUR <i>8:30 AM</i>				
3. SEX <i>F</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>6 18 89</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co.</i> MD.				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ran rooming house</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Rooming House</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Sprg.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1220 East West Highway</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Cooper</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Charity (unk.)</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>015-12-7554A</i>			17. INFORMANT <i>Olga B. Baynard, Niece</i>			ADDRESS <i>SAA</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombocytosis</i> <i>4149</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerosis & Atherosclerosis</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>6/4/79</i> 19 <i>79</i> , to <i>6/4</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6/4/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (we) (did) (did not) view the body after death.										
22b. SIGNATURE DEGREE <i>Harold W. Vercauteren M.D.</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/4/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harold W. Vercauteren</i>						22e. ADDRESS <i>1111 S. ...</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/7/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John H. ... 7400 Georgia Ave., NW</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 6 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Frederick ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MICHIGAN
DEPARTMENT OF CORRECTIONS
JANUARY 1964

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U. S. A.

Michigan

1020 East 1st Highway

X

Montgomery St. Corp.

Maryland

(unk.)

102

015-12-7854 Glen B. Gwynne, Miss

10

Lincoln Ave. Cemetery, Maryland

6/7/70

1000

1400 Georgia Ave., N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 9 15257	
FOR 1. STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUDA EVERETT HOWELL			2a. DATE OF DEATH MONTH DAY YEAR June 23, 1979		2b. HOUR 11:45A M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec., 1, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1014 Gilbert Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Automotive
13a. STATE Maryland			13b. COUNTY Mont.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Neal Howell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zenita (not known)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-26-5661	17. INFORMANT ADDRESS Ellen C. Howell-Same as items #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 3459 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>convulsion</u> (c) <u>idiopathic epilepsy</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Stat.</u> " <u>@4 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES; WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>May 14</u> , 19 <u>74</u> , to <u>June 23</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>May 19</u> , 19 <u>74</u> , and (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert S. Poole</u>		DEGREE		22c. DATE SIGNED 6-25-79.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Poole		22e. ADDRESS 4501 Conn. Ave., N. W., Wash., D. C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/27/79	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Mont., Md.	
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE <u>Lutney McCready</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary			P. Hudson			Month Day Year June 14 1979			8:39 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years birthday)		7. YRS.
female		Cauc.		Apr. 8, 1902			77		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Wash. D.C.		USA					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Gaithersburg			403 Muddy Branch Rd.			Ret. U.S. Gov.			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		#10		YES		403 Muddy Branch Rd.
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Thomas A. Hudson				Bridget L. Madigan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			578 62 3676		Mrs. Catherine Thomas #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 4 years 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>Nov 3, 1978</u> to <u>June 14, 1979</u> , that (1) (we) lost saw the deceased alive on <u>June 11, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James R. Moore, M.D.</u> MD DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6-14-79</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
James R. Moore, M.D.						Gaithersburg, Md.			
23a. BURIAL CREMATION, REMOVAL <u>Burial</u>			23b. DATE <u>6/16/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		
24. FUNERAL DIRECTOR <u>N.W. Taltavull</u> ADDRESS <u>4748 Wisc. Ave. N.W. Wash. D.C. 20016</u>						25a. REC'D BY REGISTRAR <u>JUN 18 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>	

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TO THE

ATTENTION OF

THE

MANAGER

OF

THE

LIBRARY

OF

THE

UNIVERSITY

OF

THE

STATE

OF

NEW

YORK

LIBRARY

OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 15259	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) OK-SOON HWANG			2a. DATE OF DEATH MONTH DAY YEAR 5 24 79		2b. HOUR 855 A.M.
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APR. 13 1924		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KOREA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAID		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE HOMES
13a. STATE D.C.			13b. COUNTY NONE	13c. CITY OR TOWN WASHINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-98-4455		17. INFORMANT ADDRESS LOIS M. DAY 4312 43rd ST. N.W. WASH. DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 430- DUE TO, OR AS A CONSEQUENCE OF (b) <u>INCREASED INTERVENTRICLE PRESSURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RUPTURED CEREBRAL ARTERY</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 5/23/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Left internal carotid artery		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> 19 <u>79</u> to <u>5/24</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Bernard T. Toole</u>		DEGREE M.D.		22c. DATE SIGNED 6/2/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD T. TOOLE M.D.		22e. ADDRESS 5454 Wisconsin Ave. Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6-8-1979	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G.C. Md.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS 517 11th ST. S.E. WASH. D.C.		25a. DATE REC'D. BY REGISTRAR JUN 15 1979	25b. REGISTRAR'S SIGNATURE <u>Barry McCready</u>

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15260 REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST YOUNAN ISHO										2a. DATE KNOWN OF DEATH		2b. MONTH DAY YEAR June 16 1979		2c. HOUR MIN 10 08															
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH M TH DAY YEAR JAN 18 1947		6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		June 16 1979		2d. HOUR MIN 10 08																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAG		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.																							
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEF				12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE MD				13b. COUNTY Montgomery				13c. CITY OR TOWN SILVER SPRING				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 8113 Milford Ave			
14. FATHER'S NAME FIRST MIDDLE LAST ISHO						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (NOT KNOWN)																									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 577-56-1693A						17. INFORMANT ADDRESS LUDOVINA ISHO - SAME AS ITEM 13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4391 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocardial Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																															
19a. DATE OF OPERATION <u>None</u>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE <u>John S. Rogers</u>						TITLE (SPECIFY) M.D. Dep						MEDICAL EXAMINER DATE SIGNED June 16 1979																			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS						ADDRESS 1919 SEMINARY RD. SILVER SPRING MD.																									
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL						23b. DATE 6/29/79						23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN						23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING - MONT - MD													
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS JR.						ADDRESS SILVER SPRING MD						25a. DATE REC'D. BY REGISTRAR JUL 2 1979						25b. REGISTRAR'S SIGNATURE Hickey McBrady													

DATE

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27. [illegible]
28. [illegible]
29. [illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Person may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15261	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			2b. HOUR	
			Edith Mae Jensen				June 1st. 1979			10: A. M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Nov. 20 1918		60		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New Jersey		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		2813-Aquarius Avenue				Homemaker					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2813-Aquarius Avenue			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Carl		L. Nelson		Clara				Petersen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		141-05-9801		Carl A. Jensen		2813-Aquarius Avenue Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac Arrest											
1830 DUE TO, OR AS A CONSEQUENCE OF										3-Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from Sept. 74, to June 1st. 79, that (I) (X) lost saw the deceased alive on May 31st. 19 79, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
Thomas H. Goodridge MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				6/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Thomas H. Goodridge MD				1109-Spring, Street Silver Spring, Maryland 20901							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/5/79		Arlington Cemetery		Arlington, Virginia					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hines/Rinaldi F.H. Inc.				11800-N.H.Ave. Sil.Spg., Md.		JUN 4 1979		[Signature]			

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 15262

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) IVAN W JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 6-16-79			2b. HOUR P.M.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 7 1897		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? Canadian		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Prof. Hockey Player		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6436 Kansas Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 088 05 7413		17. INFORMANT ADDRESS Ellen M. Johnson (Wife) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic squamous cell carcinoma 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Pneumonia / Congestive Heart Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 4/1 19 79, to 6-16 19 79, that (1) (we) lost saw the deceased alive on 6-15 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE Eugene E. Seligmann MD. 22c. DATE SIGNED 6-17-79									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory Brentwood PG Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE R. J. McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15263

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		3a. MONTH		3b. DAY		3c. YEAR		3d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH ESTIMATED		5		30		19		79	
Lula Bell Maye Johnson		XX									
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		5		31 19 79	
female	black	2/5/48	31 YRS.							9:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Alabama		USA				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital				Nurses Aid					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Silver Spring				YES <input type="checkbox"/> NO <input type="checkbox"/>		1148 Goodhope Drive			
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
Murry Shelton				Alberta Maye							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		421 64 3478		Mrs. Rose George-sister-4921 G St.		S.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE PERIOD BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest - handgun											
9650											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
				(approx time)				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR)				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				900xx 5/30 19 79				found shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
				house				1148 Good Hope Dr, Silver Springs, Mont Co., MD			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				M.D. Assistant				DATE SIGNED			
Margarita A. Korell, M.D.				111 Penn Street, Balto, MD 21201				5/31/79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (CITY OR TOWN COUNTY STATE)			
Burial				Harmony Memorial Park				Landover, Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED				25b. REGISTRAR SIGNATURE			
Stewart Funeral Home-4001 Benning Road, NE.				JUN 11 1979							

2 8 5 1 2 3 8 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret S. Jones			2a. DATE OF DEATH MONTH DAY YEAR June 1 1979 9 ⁰⁵ P. M.		
3 SEX Female.	4. RACE White.	5. DATE OF BIRTH MONTH DAY YEAR August 29, 1908	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Reading Renna.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Silver Spring.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reg. Nurse (Retired.)	12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland.			13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John Fox.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Brown.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b SOCIAL SECURITY NO. 217-42-1193	17 INFORMANT ADDRESS A. J. Myron Jones. (13 e)		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aortic Stenosis, Cirrhosis & Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/24, 1979, to 6/1, 1979, that (I) (we) lost saw the deceased alive on 6/1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Keith M. Ludgum MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.		23b. DATE June 5, 1979	23c. NAME OF CEMETERY OR CREMATORY Wewley Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent Md.
24. FUNERAL DIRECTOR NAME Arthur Waters		25a. DATE RECEIVED BY REGISTRAR JUN 5 1979		25b. REGISTRAR'S SIGNATURE Arthur Waters	

4 2 2 1 2 2 4



Handwritten text, possibly a signature or name, oriented vertically on the right margin.



Vertical text or stamp along the right edge, possibly reading "FOR CO. 1011 PIER 11".

Handwritten text at the bottom left, possibly a date or reference number.

Large handwritten text or signature at the bottom of the page, possibly a name or title.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #06 Film G533 7/5/79 re				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 5 2 6 5			
FOR 1- STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Pauline Kagan				2a. DATE OF DEATH MONTH DAY YEAR June 13, 1979				2b. HOUR 11:45aM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA Russia		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milliner		12b. KIND OF BUSINESS OR INDUSTRY Hat Mfg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 245 Rollins Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Schmuel Estrin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bella Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 382-09-8121A		17. INFORMANT Samuel Kagan, 245 Rollins Avenue, Rockville,				ADDRESS Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>6/12</u> 19 <u>79</u> , to <u>6/13</u> 19 <u>79</u> , that (1) <u>we</u> last saw the deceased alive on <u>6/12</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE <u>Ralph Seligman</u>				DEGREE MD				22c. DATE SIGNED 6-13-79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph Seligman				22e. ADDRESS 8630 Fenton St., Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, P. G. Maryland					
24. FUNERAL DIRECTOR Danzansky-Goldberg Mem. Chap.				ADDRESS 1170 Rockville Pk. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR Fred Charles Kahl												
REG. NO. 9 1 5 2 6 6												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRED CHARLES KAHL						2a. DATE OF DEATH MONTH DAY YEAR JUNE 15, 1979			2b. HOUR 7:45 P.M.			
3. SEX male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Mar. 31, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Sales			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Sp.						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 11550 Stewart Lane			
14. FATHER'S NAME FIRST MIDDLE LAST John Kahl				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Doyle								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 287 01 4479		17. INFORMANT Mary A. Kahl (wife)			ADDRESS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) RESPIRATORY ARREST AND PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: (c) SEVERE C.U.P.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ACUTE GASTRIC BLEEDING, PRERENAL AZOTEMIA, HYONATREMIA, THEOPHYLINE TOXICITY												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 13 JUNE 1979 to 15 JUNE 1979 , that (I) (two) last saw the deceased alive on 15 JUNE 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE William Gerling						DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 15 June 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM GERLING						22e. ADDRESS 7600 CARROLL AVE, TAKOMA PARK MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY St. Rose's			23d. LOCATION CITY OR TOWN COUNTY STATE Sharon, Pa.			
24. FUNERAL DIRECTOR W.W. Taltavull ADDRESS 4748 Wisc. Ave. N.W. Wash, D.C.						25a. DATE RECORDED BY REGISTRAR JUN 19 1979			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 15267							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL KANE					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR JUNE 5 '79 3:10 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 8 94		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8017 Herb Farm Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
13a. STATE Pennsylvania		13b. COUNTY Luzerne		13c. CITY OR TOWN Wilkes Barre		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Kane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mc Menamin		13e. STREET ADDRESS 230 Mill Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Joseph A. Lynott					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1580 RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) RETROPERITONEAL CARCINOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES MONTHS (6) MONTHS (8)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDFLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 19 79, to JUNE 5 19 79, that (I) (we) lost saw the deceased alive on JUNE 3 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard P. DeLauey				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED JUNE 5, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELAUEY MD				22e. ADDRESS 4523 HAVARD ST. SILVER SPRING, MD 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/79		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wilkes Barre, Pennsylvania			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR JUN 7 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15268

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph - Kapalko			2a. DATE OF DEATH MONTH DAY YEAR 6 18 79			2b. HOUR 7 15 AM			
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 26 96		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
13a. STATE Maryland			13b. COUNTY P.G. Co.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew - Kapalko			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Unknown			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None			
16b. SOCIAL SECURITY NO. 169-05-7159			17. INFORMANT ADDRESS Mrs. Irene Balaban (Daughter) Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest - hypertensive cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic bilateral bundle branch block, atrial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years - 1</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Chronic obstructive pulmonary disease, severe</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>April 9, 1979</u> to <u>June 18, 1979</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>June 17, 1979</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22a. SIGNATURE <u>F. W. Brennauld</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>6/18/79</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>F. W. BRENNALD</u>			22d. ADDRESS <u>831 University Blvd E, Silver Spring, Md</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>6/22/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Leckrone, Fayette Co., Pa.</u>		
24. FUNERAL DIRECTOR NAME <u>Chambers Funeral Home</u>			ADDRESS <u>Riverdale, Maryland</u>			25a. DATE REC'D. BY REGISTRAR <u>JUN 21 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15269

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Richard Edgar Kedsle			2a DATE OF DEATH MONTH DAY YEAR 06 09 79			2b HOUR 4:27p				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 6 16 '34		6 AGE (IN YEARS LAST BIRTHDAY) 44		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Med. Electronics		12b KIND OF BUSINESS OR INDUSTRY Self-employed		
13a STATE Md.			13b CITY OR TOWN Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 9666 Horizan Run Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Oliver Leroy Kedsle			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kish							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. (EYES, GIVE WAR OR DATES) Korean		17. INFORMANT Ann Kedsle		ADDRESS 9666 Horizan Run Road, Gaithersburg, Md.			

MEDICAL CERTIFICATION

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) LIVER CIRRHOSIS, ADVANCED DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

HEPATORENAL SYNDROME

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-9 19 79 to 6-9 19 79 , that (I) (we) lost the deceased alive on 6-9-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Pedro I. Matias				DEGREE		22c. DATE SIGNED 6-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pedro I. Matias				22e. ADDRESS 1811 Prince Philip Drive, Cluey Rd 20832			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 10, '79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR Gartner-Sandison				25a. DATE OF REGISTRATION JUN 15 1979		25b. REGISTRATION NO. 15269	
25c. ADDRESS 316 E. Diamond Ave., Gaithersburg, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15270	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA B. KELLY		JUNE 6 1979		11:40 AM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 04 02 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Chevy Chase, Maryland MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3716 Kenilworth Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST John Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Barnes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 214-12-8499		17. INFORMANT ADDRESS Mrs. Peggy T. King 3716 Kenilworth Dr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF STOMACH</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MOS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>WALTER E. GOOZH</u> attended the deceased from <u>JAN 31</u> , 19 <u>79</u> , to <u>JUNE 6</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>31 MAY</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.					
22b. SIGNATURE <u>WALTER E. GOOZH MD</u>				22c. DATE SIGNED 6 JUNE 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE June 9, 79		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Md.		24. FUNERAL DIRECTOR NAME ADDRESS Herbert E. Nutter 3035 W. North Ave.			
25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15271 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Ernest Kelsey										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6/7 19 79	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 21 10		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HRS. MIN. 69 YRS.		7c. DATE PRONOUNCED DEAD 6/7 19 79		2b. HOUR P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England				7b. CITIZEN OF WHAT COUNTRY? British National				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8039 Eastern Drive, #103				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dental Tech.		12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Kelsey										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Spencer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-54-3547				17. INFORMANT ADDRESS Box 283 Glasgow Rd. Joan Godfrey Ontario, LOP 1A0			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 6/8/79			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Mont., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 6-8-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.			
24. FUNERAL DIRECTOR Roy D. Bye Warner E. Pumphrey				ADDRESS 8434 Ga. Ave. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE Anthony MacBready	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15272	
1. DECEASED NAME (TYPE OR PRINT) <i>Earl Dallas Kerr</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6-20-79</i>		2b. HOUR <i>7:04 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>6 15 97</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont. Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Pk. Md.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired - A & E Inst.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Craft</i>	
13a. STATE, <i>Md.</i>		13b. COUNTY, <i>P.G.</i>	13c. CITY OR TOWN, <i>Dist. Hgts.</i>	13d. STREET ADDRESS <i>6113 Belwood St.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert W. Kerr</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eda Hoffman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>208-16-0037</i>		17. INFORMANT ADDRESS <i>Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>manipulation</i> 2000 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>diffuse histiocytic lymphoma</i> (c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>March 19 79</i> , to <i>June 20 79</i> , that (1) <i>(we)</i> last saw the deceased alive on <i>June 20 19 79</i> , and that in (my <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (1) <i>(we)</i> did <i>(did not)</i> view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/21/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. HAIDAK</i>		22e. ADDRESS <i>6728 Belcrest Rd. Hyattsville</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-25-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crooked Cr. Pre. Cem. Kittanning, Pa.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Armstrong</i>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i>		4308 Suitland Rd., Suitland, Md.		25. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
JUN 27 1979					

5 1 5 5 1 5



ADDITIONAL LINE

WINTER

JULY 1919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15273	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY TURNER KILBY						2a. DATE OF DEATH MONTH DAY YEAR JUNE 7-1979		2b. HOUR 10³⁰ AM	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR April 15, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Univ. Blvd.			
14. FATHER'S NAME FIRST MIDDLE LAST Willis - Turner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Crigler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-56-6889		17. INFORMANT ADDRESS C. H. Durham 2802 Urbana Dr. Wheaton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY-VASCULAR ACCIDENT 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MOS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from AUG. 3 - 19 78 to JUNE 7 19 79 , that (1) was last saw the deceased alive on AUG 2 19 79 , and that (1) my opinion death occurred on the date and hour and from the causes stated above, (1) was (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKA		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/7/79					
22d. ADDRESS 2309 SHOREFIELD RD - WHEATON, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Burtonsville		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis H. Barber Laytonsville, Md. 20760						25a. D. 15 REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>			

MEDICAL CERTIFICATION

29

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UNITED STATES DEPARTMENT OF AGRICULTURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15274	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Sylvester King				2a. DATE OF DEATH MONTH DAY YEAR June 25, 79		2b. HOUR 9:00 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 20, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68		7. IF UNDER 1 YEAR MONTHS DAYS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 615 Douglas Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY None			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 615 Douglas Ave,			
14. FATHER'S NAME FIRST MIDDLE LAST Amos King				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dorsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Cora King (wife) same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest & Choke DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Esophagus DUE TO, OR AS A CONSEQUENCE OF (c) Esophagus CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to June 25, 1979 , that (I) (we) last saw the deceased alive on June 25, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.											
22b. SIGNATURE Boo K. Kim DEGREE				22c. DATE SIGNED 6/27/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim, M.D., P.A.			
22e. ADDRESS Gaithersburg, Md. 20760				22f. ADDRESS 19261 Montgomery Village Ave. G-23							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-29-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Maryland					
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15275

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		June 19 1979		3:20A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		July 16 1941		37 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Nebraska		USA		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		National Naval Medical Center		Housewife		Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Florida		Duval		Jacksonville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Elmer		Clara		No		505 50 8508	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma probable primary, left lung</u> 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from May 1, 1979, to June 19, 1979, that I (we) lost saw the deceased alive on June 19, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (do not) view the body after death.		22b. SIGNATURE DEGREE MO		22c. DATE SIGNED 6/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Kevin M. Murray, M.D.		National Naval Medical Center, Bethesda, Md.		Burial		June 25, 1979	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Capitol Funeral Service		Fairfax, Virginia		JUN 25 1979		[Signature]	





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15276

1. DECEASED NAME (TYPE OR PRINT) LIESELOTTE				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-16-79				2b. HOUR A M	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1928		6. AGE (IN YEARS) (LAST BIRTHDAY) 50 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 401 MANNAKEE ST.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 MANNAKEE ST.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH KAUFMANN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSINA SCHROLL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 041-30-7016		17. INFORMANT ADDRESS HAROLD E. KNEELAND (SAME AS 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Alcoholism. 303- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 6-16-79	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-19-79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTG. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES P/A ROCKVILLE MD.				25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy			



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6-10-79

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7330 Old Georgetown Rd.
Bethesda, Maryland

John D. Bell

John D. Bell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15277			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MINNIE KOPERWAS				2b. HOUR 2:17 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 15 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS HASH MARKOWICZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHINDLE SPIEGEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 578-48-0634-D		17. INFORMANT ADDRESS William Leon Koperwas, Son, Same as #13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia 2500 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days. 4 years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6/8/79, 19 to 6/13/79, 19, that (I) (we) lost saw the deceased alive on 6/12/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel Dessoiff, M. D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/79.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel Dessoiff, M. D.				22e. ADDRESS 4501 Connecticut Avenue, N. W. Wash., D. C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/14/1979		23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HILLSIDE PR. GEO. MD.	
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL F.H.				25. REGISTRAR'S SIGNATURE JUN 18 1979			
232 CARROLL STREET, N. W., WASHINGTON, D. C.				25b. REGISTRAR'S SIGNATURE			

112211

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

16 6552 6/27/79 83

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15278

1. DECEASED NAME (TYPE OR PRINT) Donald Edward LANE			2a. DATE OF DEATH MONTH DAY YEAR May 30 1979		2b. HOUR 6:05P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 10 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE D. C. COUNTY 13b. COUNTY CITY OR TOWN 13c. Washington YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS 3900 Watson Place, N. W.		
14. FATHER'S NAME FIRST MIDDLE LAST John Albert Lane			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Payson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1931-53	17. INFORMANT ADDRESS Mrs. Virginia P. Lane See item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 3, 1979, to May 30, 1979, that (I) (we) lost saw the deceased alive on May 30, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE C. N. Held, M.D.				22c. DATE SIGNED May 31, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. N. Held, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-1-79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION Washington		23e. COUNTY D.C.		23f. STATE	
24. FUNERAL DIRECTOR NAME Lee's Funeral Home & Crematory Washington, D.C.				25a. DATE REC'D. BY REGISTRAR JUN 4 1979	
25b. REGISTRAR'S SIGNATURE [Signature]					

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15279
REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Agnes V. Lerner</u>			2a. DATE KNOWN OF DEATH ESTIMATED <u>June 2 1979</u>			2b. HOUR OF DEATH <u>8 PM</u>		
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>11</u> DAY <u>18</u> YEAR <u>1896</u>	6. AGE (IN YEARS) LAST BIRTHDAY <u>83</u> YRS.	IF UNDER 1 YR. MONTHS <u></u> DAYS <u></u>	IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	2c. DATE PRONOUNCED DEAD <u>June 2 1979</u>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WASHINGTON, D. C.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <u>Berksington Kensington Gardens, MD</u>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Montgomery MD</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		
13a. STATE <u>MD</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Scottdale</u>		
14. FATHER'S NAME FIRST <u>ROBERT</u> MIDDLE <u>LAWSO</u> LAST <u>HARDEN</u>			15. MOTHER'S MAIDEN NAME FIRST <u>IDA</u> MIDDLE <u>G.</u> LAST <u>HERBERT</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>NO</u>		
16b. SOCIAL SECURITY NO. <u>578-10-2399</u>			17. INFORMANT <u>FRANCIS M. LARNER</u>			18. ADDRESS <u>SAME AS 13 HUSBAND</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: <u>4292</u> (b) <u>Arteriosclerosis Cardiovascular Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fractura Rt. Hip</u>			
19a. DATE OF OPERATION <u>Feb 27 79</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fract. Rt. Hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>130 79 Fall at home</u>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>130 79</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fall at home</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <u>Home</u>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>	21f. LOCATION STREET <u>New Hampshire Ave</u> CITY OR TOWN <u>Scottdale</u> COUNTY <u>Montgomery</u> STATE <u>MD</u>	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) <u>M.D. Dep.</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>JOHN S. ROGERS</u>		ADDRESS <u>1919 SEMINARY ROAD, SILVER SPRING, MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>6/5/79</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	23d. LOCATION CITY OR TOWN <u>SUITLAND</u> COUNTY <u>PRI GEO</u> STATE <u>MD.</u>
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD 20901</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1979</u>	25b. REGISTRAR'S SIGNATURE <u>Fitzroy McBrady</u>

1 2 3 4 5

MEMORANDUM FOR THE RECORD

XX

WASHINGTON, D. C. U.S.A.

TO THE DIRECTOR, FBI

RECEIVED

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10

10

10

10

NO. 100-10-1399 FRANCIS M. LARNER SATE AS IS HUSBAND

[Faint, illegible handwritten text]

JOHN S. RIVERS 1919 SEYMOUR ROAD, SILVER SPRING, MD.

BURIAL FRANCIS M. LARNER 6/17/79 CEDAR HILL CEMETERY SWILLAND, MO. 65750
500 W. BROAD ST., SILVER SPRING, MD. 20901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 5 2 8 0				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR HOUR				
IDA B. Leader					6 3 79 9 ⁰⁵ PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR May 8, 1901		78 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Poland		U. S. A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE COUNTY Maryland Montgomery					13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. 11600 Lockwood Drive, #202		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Morris Edelman					FIRST MIDDLE LAST Rebecca Snider				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					577-22-8418		Gilbert S. Leader Same as No. 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) - CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 20 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Adenocarcinoma of sigmoid colon - Pleural metastases									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (we) (did not) attended the deceased from April 1 st to June 3 rd 1979, that (I) (we) lost saw the deceased alive on June 3 rd 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE Blumenthal			22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Luis BERTOLINA M.D.					5480 Wisconsin Avenue, Chevy Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		6/5/1979		Cemetery Dist. of Col. Lodge		Washington, D. C.			
24. FUNERAL DIRECTOR					25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE		
Donald M. Stein Hebrew Memorial F.H.					JUN 6 1979		History/for Burial		
232 Carroll Street, N. W. Washington, D. C.									



I have been thinking of you very much lately
 and wondering how you are getting on.
 I hope you are well and happy.
 I have been very busy lately
 but I will try to write to you more often.
 I have been thinking of you very much lately
 and wondering how you are getting on.
 I hope you are well and happy.
 I have been very busy lately
 but I will try to write to you more often.
 I have been thinking of you very much lately
 and wondering how you are getting on.
 I hope you are well and happy.
 I have been very busy lately
 but I will try to write to you more often.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15281

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret C. Lee			2a. DATE OF DEATH MONTH DAY YEAR June 23, 1979		2b. HOUR 5:55 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 27, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST James Collins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Collins McCreish			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 064-03-7571		17. INFORMANT ADDRESS Charles C. Lee (Son), Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) RECURRENT GRAM NEGATIVE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) SENILE INANITION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): SENILE INANITION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from March 1976 to June 23, 1979 , the (1) (we) last saw the deceased alive on June 20, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Martin C. Shargel				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL M.D.				22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON MD-20795			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUN 28 1979			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 2 3 4



PSB-1346



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15282	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
			SING NOM LEE			6-30-79			12 ³⁰ AM		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		
Female			Oriental			Dec. 12, 1890			88 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Canton, China			United States						Montgomery MD.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			WASHINGTON ADVENTIST HOSPITAL			Housewife			At home		
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Maryland			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET ADDRESS					
Unknown			Unknown			8112-New Hampshire Ave.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			578-64-8839			Harrison Lee (Son)			Fairfax, Va. 22030		
						9302-Christopher Street					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i>											
4140 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<i>Senility Renal Insufficiency</i>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d INJURY OCCURRED			21e PLACE OF INJURY			21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>4/18</i> , 19 <i>79</i> to <i>6/29</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/29</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE			22c DATE SIGNED		
<i>Antonio Uy</i>						MD			<i>6/30/79</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS					
ANTONIO UY MD						831 Univ. Blvd E #25 Silver Spring, Md 20903					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION		
Burial			July 2, 1979			Fort Lincoln Cemetery			Bretwood, Maryland		
24 FUNERAL DIRECTOR						25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
J.Wm.Lee's Sons Co. 300-4th St., NE, Wash., DC 20002						JUL 6 1979			<i>Hofrey McCready</i>		



Female	Orizaba	Dec. 12, 1990	88
Canton, China	United States	xx	Montgomery
Takoma Park			Honolulu
Maryland	Montgomery Silver Spring	x	Old-New Hampshire Ave.
Unknown	Unknown		
No	518-64-0839 Harrison Lee (son) 9305-Christopher Street Fairfax, Va. 22030		

July 2, 1979 Fort Lincoln Cemetery, Brentwood, Maryland

1. Lee's Sons Co. 300-4th St., N.E., Wash., DC 20005



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO. 15283											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Frances		MIDDLE E.		LAST Leggett		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
FRANCES						LEGGETT		6		21 1979		11:55 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		7 5 1916		62		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Georgia		U.S.A.				Montgomery						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park		Wash. Adventist Hosp.		Supervisor - F.H.A. - U.S. Gov.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Pr. Geo.		Mt. Rainier		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4210-Russell Ave.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST Thomas		MIDDLE B.		LAST West		FIRST Fay		MIDDLE W.		LAST Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		-		252-01-4954		Daniel W. Leggett -		2348-Amour Court		Titusville, Fla.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1509		Hypotension - Unresponsive to Dopamine											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Cirrhosis of liver		DUE TO, OR AS A CONSEQUENCE OF									
		Cancer of Esophagus		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		G.I. Bleed											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-12, 1979, to 6-21, 1979, that (I) (we) last saw the deceased alive on 6-21-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
		Alton R. Anderson		MD				6-22-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Alton R. Anderson													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		6/26/1979		West View Cem.		Atlanta		Fulton		Georgia			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Nalley's F.H. Inc.		Mt. Rainier, Md.		JUN 25 1979		History McCreedy							

MEDICAL CERTIFICATION

29

4800 BP

3 8 5 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 2 8 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR MIN	
ALFRED L. LEVITOV				6 5 79		24		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		WHITE		APRIL 21, 1915		64 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, DC		U.S.A.				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL		MANUFACT. REP.		FOOD			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
MAX		ROSE		NO		578-09-9235		FLORENCE LEVITOV, WIFE, SAME AS No. 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431- RIGHT CEREBRAL HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		4-5 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) CEREBRAL VASCULAR ARTERIOSCLEROTIC DISEASE		INDEFINITE					
		(c) HYPERTENSIVE VASCULAR DISEASE		15-20 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from JULY 24, 1969, to JUNE 5, 1977, that (I) (we) last saw the deceased alive on JUNE 4, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22a. SIGNATURE		DEGREE		22c. DATE SIGNED					
Florence S. Marcus, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/5/79					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS							
Lawrence Marcus, M. D.		1111 Spring Street, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL		6/7/1979		JUDEAN MEMORIAL GARDEN		OLNEY		MONTGOMERY MD.	
24 FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE					
DONALD M. STEIN HEBREW MEMORIAL F.H.U.		JUN 8 1979		Anthony McCreedy					
232 CARROLL STREET, N. W., WASHINGTON, D. C.									

48521



RECEIVED
JAN 10 1971
FBI - NEW YORK

DATE

TIME

TO: DIRECTOR, FBI (100-441111)

FROM: SAC, NEW YORK (100-157411)

SUBJECT: [Illegible]

RE: [Illegible]

100-157411-100

100-157411-101

100-157411-102

100-157411-103

100-157411-104

100-157411-105

100-157411-106

100-157411-107

100-157411-108


 1- FOR
STATE
REGISTRAR

 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 15285
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE ANNIE LAST LEWIS			2a. DATE KNOWN OF DEATH ESTIMATED MONTH 6 DAY 16 YEAR 1979		2b. HOUR 11:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 4 YEAR 97	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16,609 Jilrick Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST HARRY MIDDLE B. LAST MATHIOT		15. MOTHER'S MAIDEN NAME FIRST EFFIE MIDDLE VIRGINIA LAST DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 265 - 98 - 1478		17. INFORMANT ADDRESS Drive Ken, Md. Mrs. Ida M. Clark - daughter 4407 Ambler	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Granulocytic Leukemia</u> 2056 DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Myeloproliferative Disease</u> DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Richard L. Whelton</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>June 17 1979</u>	
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON		ADDRESS <u>7100 Baltimore Ave. Catonsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6-20-79	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo/ Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <u>Harry McBrady</u>	
25c. ADDRESS 500 University Blvd. West Silver Spring, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 691168
7 9 1 5 2 8 6

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
DANIEL MICHAEL LIGOCKI		JUNE 30, 1979		1235am	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR IF UNDER 24 HRS	
MALE	CAUCASIAN	JUNE 30, 1979	00 YRS	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA	NATIONAL NAVAL MEDICAL CENTER		N/A		N/A
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
VIRGINIA		ARLINGTON	ARLINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
THOMAS DANIEL LIGOCKI		LINDA MARIE BAKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO		392-62-5147	THOMAS LIGOCKI 1614 NORTH QUEEN ST ARLINGTON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7566 DUE TO, OR AS A CONSEQUENCE OF RESPIRATORY INSUFFICIENCY ABSENCE OF LEFT DIAPHRAGM WITH MASSIVE HERNIATION OF ABDOMINAL CONTENTS DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from		JUNE 30 19 79 to JUNE 30 19 79, that (s) (we) last			
saw the deceased alive on		JUNE 30 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Donald S. BAIR		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Donald S. BAIR, M.D.		NNMC BETHESDA, MD. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		7-6-79		St. Adalberts Cem.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MARSHALL FUNERAL HOME WASHINGTON, DC		JUL 9 1979		[Signature]	

MEDICAL CERTIFICATION

C 8

801124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9

15287

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLYDE A. LIMERICK			2a. DATE OF DEATH MONTH DAY YEAR June 17 79			2b. HOUR 2:55 P M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG. 20 1907		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY MECHANIC	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1235 POTOMAC VALLEY ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-09-6968		17. INFORMANT ADDRESS SALLY A. ROBBINS 17215 DONORA RD., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 1977 to June 17 1979 , that (I) (we) last saw the deceased alive on June 14 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M R Cascardo				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL R CASCARDO				22e. ADDRESS 2400 BALBIC LT POTOMAC Md 20854					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6-18-79		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX VA.			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE John McReady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		7 9 1 5 2 8 8 REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)				3 SEX		4 RACE		5. DATE OF BIRTH		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Theodore C. LONNQUEST, JR.				Male		Caucasian		Feb. 24 1925		June 20 1979		4:58P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Florida				USA				54 YRS.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				9 BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR OCCUPATION			
Bethesda				National Naval Medical Center				Montgomery MD.		Military			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)													
U. S. Navy													
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4214 Thornapple Street			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Theodore C. Lonnquest Sr.						Alice Marie Born							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes				1945-75		176 32 0041		Mrs. Mary K. Lonnquest See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery disease</u> (c) <u>Status post artery bypass surgery</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I/ (this hospital) attended the deceased from <u>June 15</u> 19 <u>79</u> to <u>June 20</u> 19 <u>78</u> that I/ (we) last saw the deceased alive on <u>June 20</u> 19 <u>79</u> and that in my/ (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)													
22b. SIGNATURE <i>K. M. Begelman</i>						DEGREE MD		22c. DATE SIGNED 6/21/79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. M. BEGELMAN, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation				6/22/79		Metropolitan Crematory		Alexandria Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robt. A. Pumphrey Funeral Home, Bethesda, Md.						JUN 27 1979		<i>Jeffrey M. Cready</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 5 2 8 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH
Margaret L. Lott					MONTH DAY YEAR
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))
Female		Caucasian		MONTH DAY YEAR	6 15 79
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U. S. A.		66 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Bethesda		Suburban Hospital		Montgomery MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. CITY OR TOWN		13b. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?	
Md.		Montgomery		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Jesse C. Graves		Sarah J. Harding		No	
16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY	
214-03-9372		Randolph B. Lott		1749 IMMEDIATE CAUSE (a) Cardiac Arrest	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) Carcinoma of the breast w/ metastasis	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 19 79 to present 19, that (I) (we) last saw the deceased alive on May 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
John J. Merendino					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
John J. Merendino		11620 Kemp Mill Rd., Silver Spr., Md.		JUN 18 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/18/79		George Washington Cem. Adelphi, Maryland	
23d. FUNERAL DIRECTOR NAME		23e. ADDRESS		23f. DATE REC'D. BY REGISTRAR	
Warner E. Pumphrey, Inc.		8434 Ga. Ave. Silver Spring, Md.		JUN 18 1979	

[Faint, mostly illegible text spanning the main body of the page, appearing to be a list or series of entries.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15290 REG. NO.	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William J. Luncetord</i>										2b. HOUR <i>9:20 AM</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH (MONTH DAY YEAR) <i>May 20 1935</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>44 YRS.</i>	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	7c. DATE PRONOUNCED DEAD <i>June 16, 1979</i>		7d. MONTH DAY YEAR <i>June 16 1979</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>					
10. CITY OR TOWN OF DEATH <i>S. L. Spg.</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bartender</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>S. L. Spg.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2407 Randolph Rd.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Amos W. Luncetord</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Hogan</i>				16. SOCIAL SECURITY NO. <i>578-44-7555</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes</i>				17. INFORMANT ADDRESS <i>Mary A. Luncetord Wheaton, Md.</i>				17b. 2407 Randolph Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <i>Huntington's Chorea</i> (b) <i>Huntington's Chorea</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>											
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>Dep.</i>				DATE, SIGN <i>June 16, 1979</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>				ADDRESS <i>Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>6/14/79</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			
23d. LOCATION CITY OR TOWN <i>Rockville, Maryland</i>				23e. COUNTY <i>Montgomery</i>				23f. STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey, Inc.</i>				24b. ADDRESS <i>8434 Ga. Ave. Sil. Spr., Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>			
25b. REGISTRAR'S SIGNATURE <i>Patrick McCreedy</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15291	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. AGE (IN YEARS LAST BIRTHDAY)	
LENA M. LUNCH		Female		89 YRS	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
February 2, 1890		89		MONTGOMERY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Russia		U. S. A.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
SILVER SPRING		HOLY CROSS HOSPITAL		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Louis		Sarah		No	
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS	
Gladys Lunch (Same as # 13)		577-10-21150		(Unknown)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		19. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410 -		Acute myocardial infarction		24 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b. Chronic heart disease		10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/6 to 6/16 1979, that (I) (we) lost saw the deceased alive on 6/6 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
Myron L. Lenkin MD		6/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
MYRON L. LENKIN MD		2309 SHOREFIELD RD WHEATON, MD		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
6/18/1979		MOUNT LEBANON		HYATTSVILLE P. G. MD.	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D BY REGISTRAR		26. REGISTRAR'S SIGNATURE	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		JUN 19 1979			
232 CARROLL STREET, N.W., WASHINGTON, D.C.					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15292	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John W. Maher										ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 16 1979	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5-30-1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD June 16 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6702 Pawtucket Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Law	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS 6702 Pawtucket Road			
14. FATHER'S NAME FIRST MIDDLE LAST John J. Maher				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown -- Larkin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. I 579-24-6200		17. INFORMANT ADDRESS Mary M. Scribner, Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 411- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John M. Ball				TITLE (SPECIFY) M.D. De Puty				DATE SIGNED June 16, 1979			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd., Beth., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				ADDRESS 5130 Wis. Ave., N.W.		25a. DATE OF BURIAL JUN 19 1979		25b. REGISTERED SIGNATURE			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 2 9 3

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST George P.		MIDDLE T.	LAST MALONEY		2a. DATE OF DEATH MONTH DAY YEAR 6 8 79		2b. HOUR 9:30 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 21 18		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MARYLAND		13b. COUNTY PRINCE GEO.	13c. CITY OR TOWN BELTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6011 AMMENDALE ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERONICA MOONEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE	17. INFORMANT ADDRESS BROTHER PATRICK F. POWER SAME AS 13 FRIEND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 VENTRICULAR ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) METABOLIC DERANGEMENT. DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHOGENIC CARCINOMA (Rt) 1629		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes days months
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE			
19a. DATE OF OPERATION 5/22/79 & 6/4/79	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHOGENIC CARCINOMA	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5/22/79 to 6/8/79, that (I) (we) lost saw the deceased alive on 6/8/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Sol Shaz	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6.9.79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL SHAZ		22e. ADDRESS 4805 BEL PRE ROAD ROCKVILLE, Md. 20853			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6/11/79	23c. NAME OF CEMETERY OR CREMATORY CHRISTIAN BROTHERS CEME BELTSVILLE PRI GEO MD.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JUN 12 1979	
		25b. REGISTRAR'S SIGNATURE F. J. Shaz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 2 3 4 5



CONTINUED

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE

NAME

ADDRESS

CITY

STATE

DATE

TIME

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

15294

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH ELANOR MANSELL			2a. DATE OF DEATH MONTH DAY YEAR JUNE 15 1979		2b. HOUR 4:5 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 8 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN BELTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 4617 BLACKWOOD ROAD		14. FATHER'S NAME FIRST MIDDLE LAST CITRALES WINDSOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA FARLEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO.		17. INFORMANT DONALD E. MANSELL		ADDRESS 4617 BLACKWOOD RD.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Right Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 10 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus, A.S.H.D., Renal Failure, Hypoxia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-7 , 19 66 , to 6-15 , 19 79 , that (I) was lost saw the deceased alive on 6-14 , 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.							
22b. SIGNATURE Russell B. Arnold		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell B. Arnold M.D.		22e. ADDRESS 1106 Spring Street, Silver Spring, Md. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 18, 1979		23c. NAME OF CEMETERY OR CREMATORY First Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PR MD	
24. FUNERAL DIRECTOR NAME TAKOMA F.H., Inc.		ADDRESS 254 CARRON ST., N.W. WASH., D.C. 20012		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE Robert McCreedy	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1951-1952



Mr. Tolson

Mr. Tamm

Mr. E. A. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

Mr. Egan

Mr. Gurnea

Mr. Harbo

Mr. Mohr

Mr. Nease



Mr. Belmont

Mr. Winterrowd

Mr. Holloman

Mr. Tamm

Mr. Rosen

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Edna Corrine Martz</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 6, 1979</i>		2b. HOUR <i>8 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10-19-1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>GAITHERSBURG</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ASBURY METHODIST HEALTH CARE CENTER</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>EDGAR</i> <i>CLAGGETT</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARTHA</i> <i>DAVIS</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>578-54-3426D</i>		17. INFORMANT <i>DAUGHTER</i> ADDRESS <i>SILVER SPRING, MD.</i> <i>CUYLER EDWARDS 13217 BREGMAN ROAD.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2500

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*3 days**years**years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>4-19-75</i> to <i>6/6-19-79</i> , that (I) (we) saw the deceased alive on <i>5/29-19-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Greger</i>	DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>6/2/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Greger</i>		22e. ADDRESS <i>12105 Gaithersburg Rd</i> <i>Silver Spring, Md</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>6/9/79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>BRENTWOOD PRI GEO MD.</i>
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR <i>JUN 12 1979</i>	25b. REGISTRAR'S SIGNATURE <i>John H. Brady</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

2 1 2 2 2 2

Edna (Mrs. Mary)

MARYLAND MONTGOMERY U.S.A. KY MONTGOMERY

GATHERING ASSEMBLY METHODIST HEALTH CARE CENTER HYUNDAI

MARYLAND MONTGOMERY SILVER SPRING X 1217 BEECHMAN ROAD

EDGE CLAGGETT MARTIN DAVIS DAUGHTER SILVER SPRING MD.

572-21-2100 CIVIL RIGHTS 1217 BEECHMAN ROAD

3 0 1 2 A and CVA

4 0 1 2 O states

4 0 1 2 H. H. H. H. H.



22 2/10 22

22

2/10

Handwritten signature
Greene

1217 Beechman Rd
Silver Spring, MD
20901

500 W. BLVD. N. SILVER SPRING, MD. 20901
FRANCIS J. COLLINS
2/10/79
FT. LINCOLN CENTER
BETHLEHEM
THE CEO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		7 9 1 5 2 9 6	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy H. MCCALL			2a. DATE OF DEATH MONTH DAY YEAR June 17 1979
3. SEX Female			2b. HOUR 7:50P M
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 1926	
6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Potomac			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9000 Belmart Road	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Hinkle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Johnson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 30 4087	
17. INFORMANT ADDRESS Craig C. McCall See item 13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>OVARIAN CANCER; Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Leukemia, Acute myelogenous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Leukemia, Acute myelogenous</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>June 1</u> 19 <u>79</u> , to <u>June 17</u> 19 <u>79</u> , that (i) (we) last saw the deceased alive on <u>June 17</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Gary W. Smith</u>		22c. DATE SIGNED June 18, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY W. SMITH</u>		22e. ADDRESS National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REINTERMENT (SPECIFY) Burial		23b. DATE 6-20-79	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home, Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR JUN 21 1979	
25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			



U.S.A.

National Level Medical Center

Montgomery, Alabama

Post Office

Box 13

Montgomery, Alabama

36101

Alabama

U.S.A.

Montgomery, Alabama

Post Office

Box 13

Montgomery, Alabama

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		7 9 1 5 2 9 7		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Peggy Ann McCarthy				June 15, 1979								5:30 a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Oct. 4, 1945		33		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda, Md		Clinical Center, (NIH)				Housewife							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21113			
Maryland		A.A. Co.		Odenton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1328 Passage Drive		21113			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Ernest Charles Louis Baier				Margaret Martin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				214-44-4205		Mr. James McCarthy (husband) same as above							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diffuse Histiocytic Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <u>June 9, 1979</u> to <u>June 15, 1979</u> , that (X) (we) last saw the deceased alive on <u>June 15, 1979</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.													
22b. SIGNATURE <u>Stuart E. Selowick, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>6/15/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart E. Selowick, M.D.</u>				22e. ADDRESS <u>National Institutes of Health The Clinical Center, Bethesda, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/18/1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Md</u>		23e. 20205					
24. FUNERAL DIRECTOR NAME <u>Walter Brooks Bradley Inc. Dundalk Md</u>				25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Pietro McCarthy</u>							

1952

(5)

PAID IN FULL

1952



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15298

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elbert F. McConnell			2a. DATE OF DEATH MONTH DAY YEAR 6-12-79			2b. HOUR 10 A.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 14 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11947 Marmary Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Animal Caretaker		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William B. McConnell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Witt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS 11941 Marmary Rd., Gaithersburg, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JULY 7 1979 to JUNE 12 1979 , that (I) (we) lost the deceased alive on JUNE 7 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert C. Daddario M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. DADDARIO					22e. ADDRESS 5413 CEDAR LANE BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/16/79		23c. NAME OF CEMETERY OR CREMATORY McConnell's Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Jonesville, Lee, Virginia			
24. FUNERAL DIRECTOR NAME Gartner-Sandison F. H.					25a. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <i>Robert C. Daddario</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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13
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15299

1. DECEASED NAME (TYPE OR PRINT) Earl marcus McMains			2a. DATE OF DEATH MONTH DAY YEAR 6 30 79		2b. HOUR 11:35 AM
3. SEX m	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4 - 5 - 23	6. AGE (IN YEARS LAST BIRTHDAY) 56	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH mont. Co. MD.		
10. CITY OR TOWN OF DEATH Takoma Park Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgr. Tech.	12b. KIND OF BUSINESS OR INDUSTRY V.A.	
13a. STATE md.			13b. COUNTY pg.	13c. CITY OR TOWN Hyatts. md.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Lerry m McMains			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Getz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 184-18-7911	17. INFORMANT wife ADDRESS Anne M. McMains same as 13c.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/30 , 19 79 , to 6/30 , 19 79 , that (I) (we) last saw the deceased alive on 6/29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alfred Munzer		DEGREE MD		22c. DATE SIGNED 6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred Munzer M.D.		22e. ADDRESS 7600 Carroll Avenue Takoma Park			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jul. 3, 1979	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE Anthony McHenry	
500 University Blvd., W. Silver Spring, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1950

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1953

1954-18-7711
James H. McInerney
June 18, 1954

500 University Blvd., W. Silver Spring, Md.
Francis J. Collins
Dec. 3, 1957
For: Lincoln

Greenwood, W. Va.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15300

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alexander McMichael			2a. DATE OF DEATH MONTH DAY YEAR June 12, 1979		2b. HOUR 7:10PM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 2, 1889		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
13a. STATE MARYLAND		13b. CITY OR TOWN MONTGOMERY		13c. STREET ADDRESS 14515 FISKE DRIVE		
14 FATHER'S NAME FIRST MIDDLE LAST ALLEN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE CASCADEN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 082-05-2350		17 INFORMANT ADDRESS RACHEL B. McMICHAEL SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C-V Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMINATION 1 wk 7 years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Card Prostate - Interstitial Pneumonitis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 75 19 75 to 6/12 19 79 , that (I) (we) last saw the deceased alive on 6/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE C. H. H. 1980		DEGREE MD		22c. DATE SIGNED 6/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. H. 1980		22e. ADDRESS 1811 P. P. L. Hwy. Dr., Olney MD 20852				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/15/79		23c. NAME OF CEMETERY OR CREMATORY NORTH CEDAR HILL CEME.		
23d. LOCATION CITY OR TOWN COUNTY STATE PHILADELPHIA PA.						
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		24b. ADDRESS 500 UNIV. BLVD W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JUN 18 1979		
25b. REGISTRAR'S SIGNATURE Robert McBrady						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JULY 2 1969

WHITE

WHITE

U.S.A. PENNSYLVANIA

ACCOUNTANT

INLET FIGHT DRIVE

MONTGOMERY SELFIE DRIVE

REARVIEW

CASCHEN

WHITE

MONTGOMERY

ALLAN

NO 012-0-2370 JACQUELINE D. MONTGOMERY SALT AC 12 WHITE

200 LINCOLN W. SILVER STATION NO. 22901
FRANCIS T. COLLINS
BUTLER 11575 NORTH CEDAR HILL DRIVE PHILADELPHIA PA.

DR. MAYLE RELEASED TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 15301							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY	
FIRST MIDDLE LAST				6/27/79		179		6:55 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		81 YRS.		MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
Mass.		USA				Montgomery County			
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Suburban		Secretary		Agricult. Coll.			
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15b. STATE		15c. COUNTY		15d. CITY OR TOWN		15e. INSIDE CITY LIMITS?	
Md.						Burtonsville		YES <input type="checkbox"/> NO <input type="checkbox"/>	
16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18. STREET ADDRESS					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		14413 Hollyhock Way					
Henry A. Hollis		Edwina							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19b. SOCIAL SECURITY NO.		20. INFORMANT		21. ADDRESS			
No		270-30-5679B							
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		23. IMMEDIATE CAUSE (a)		24. DUE TO, OR AS A CONSEQUENCE OF		25. DUE TO, OR AS A CONSEQUENCE OF		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436-		Cerebrovascular Accident		Arteriosclerosis				None	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED		27c. AUTOPSY?		27d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
28a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28b. TIME OF INJURY		28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
29a. INJURY OCCURRED		29b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		29c. LOCATION		CITY OR TOWN		COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET				STATE	
29d. I certify that (I) (this hospital) attended the deceased from		19 78		to		6/27		19 79	
saw the deceased alive on		6/27		19 79		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
29e. SIGNATURE		DEGREE		29f. DATE SIGNED					
J. G. WARD		M.D.		6/27/79					
30. PHYSICIAN'S NAME (TYPE OR PRINT)		31. ADDRESS							
J. G. WARD		6116 Robinwood Rd, Bethesda, Md.							
32a. BURIAL, CREMATION, REMOVAL (SPECIFY)		32b. DATE		32c. NAME OF CEMETERY OR CREMATORY		32d. LOCATION		CITY OR TOWN	
Removal		6/27/79				COUNTY		STATE	
33. FUNERAL DIRECTOR		34. ADDRESS		35. DATE RECEIVED BY REGISTRAR		36. REGISTRAR'S SIGNATURE			
Anatomy Board		Balto., Md.		JUL 3 1979		J. G. WARD			

100001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information retained by the hospital or attending physician.

DHMM-16 1/71 30M
(VR A15 (4))

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information retained by the funeral director of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				1 5 3 0 2			
1. DECEASED-NAME (Type or print) First Middle Last <i>Mary Mestel</i>				2a. DATE OF DEATH Month Day Year <i>June 13 1979</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 10, 1905</i>		6. AGE (In years lost birthday) <i>74</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Brookgrove Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1220 East West Highway</i>		14. FATHER'S NAME First Middle Last <i>Not Known</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Gissele Plotchick</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>520-22-2538</i>		17. INFORMANT <i>Nathan Mestel</i>		1500 South Ocean Drive <i>Hollywood, Florida 33019</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain pneumonia</i> <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): <i>stomach the underlying cause lost.</i> (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE (c) <i>Recurrent CVA</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 days</i> <i>10 days</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/12/79</i> to <i>6/15/79</i> , that (I) (we) saw the deceased alive on <i>6/12/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. H. L. L. L. L.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/13/79</i>	
22d. PHYSICIAN'S NAME (Type) <i>C. H. L. L. L. L.</i>				22e. ADDRESS <i>18111 P. Phillips Rd Olney Md 20832</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/14/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>	
24. FUNERAL DIRECTOR <i>Donald M. Stein Hebrew Memorial F.H.</i>				25a. RECEIVED BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Harry McCurdy</i>	
232 Carroll Street, N. W. Washington, D. C.							

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STATE OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15303

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Julie Marie Miller			2a. DATE OF DEATH MONTH DAY YEAR June 19, 1979		2b. HOUR 12:55 AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 01/16/1950		6 AGE (IN YEARS LAST BIRTHDAY) 29 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR INDUSTRY Postal Serv.	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Fred. B. Miller			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Sears		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-56-5149		17 INFORMANT Mildred S. Miller, Same as #13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Osteogenic sarcoma, metastatic to lungs and elsewhere DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that xx (this hospital) attended the deceased from 03 June , 19 79 , to 19 June , 19 79 , that x (we) lost saw the deceased alive on 19 June , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above x (we) (did) not view the body after death.					
22b. SIGNATURE Freddie Ann Hoffman			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-19-79
22d. (PHYSICIAN'S NAME) (TYPE OR PRINT) Freddie Ann Hoffman, MD			22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/20/79	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland			25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jeannette -- Mogul			2a. DATE OF DEATH MONTH DAY YEAR June 5 1979			2b. HOUR 10⁴⁰ AM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3/31/99		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL 5213 Cedar Lane Bethesda, MD 20014		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE D. C.		13b. COUNTY ---	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3120 Appleton St	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Fuchs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Schnitzer		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 578-42-2116		17. INFORMANT ADDRESS Mrs. Selma Gorin, 3120 Appleton st. Wash DC					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Septicemia**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**days****3320**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Parkinsons Disease****years**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 78 , to June 5 19 79 , that (I) (we) last saw the deceased alive on June 5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Irwin Ardum, M.D.				DEGREE MD		22c. DATE SIGNED June 5, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irwin Ardum, M. D.				22e. ADDRESS 5454 Wisconsin Ave N.W., Wash. D. C.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun 6, 1979		23c. NAME OF CEMETERY OR CREMATORY King David		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Ch Fairfax Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg, Inc 1170 Rockville Pike Rockville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Patricia K. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 3 0 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
FRANCES E.		moore						6/25/79	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Jan 30 1886		93 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS. HOURS MIN.	
Kentucky		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
Potomac		Potomac Valley Nursing Home		Housewife		own home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Sil. Spring				1309 Ruppert Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
(unknown)		Embry		(unknown)		Embry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
no		none		401-14-8099		Richard L. Moore-son-		(same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 4289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Heart failure</u> (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> 19 <u>77</u> , to <u>June 25</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 22</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>M. Cascard</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/25/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
MIGUEL R CASCARDO		12400 130 BANK POTOMAC, Md 20854							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6-28-1979		George Washington		Adelphi Pr. Georges Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey Inc.		8434 Ga. Ave.		JUL 2 1979		M. Cascard			
		Mack B. Bickins, S. Md.							

2002-1-28

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15306	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Mzude Lee Morgan</u>										2a. DATE KNOWN OF DEATH ESTIMATED <u>June 29 1979</u>	
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Nov 21 1916</u>		6. AGE (IN YEARS) LAST BIRTHDAY <u>62 YRS.</u>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <u>June 29 1979</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>				7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery, MD.</u>	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Manor Care Wheaton</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Bur. of Engrav.</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MD.</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Brookville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>9 Treadway Ct.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>R. A. Bryant</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Flemingline Hughes</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>216-44-7513</u>		17. INFORMANT <u>husband</u>		ADDRESS <u>same as 13e</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dia</u> <u>4391</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Krs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Fract. L. Hip & Subdural Hematoma</u>											
19a. DATE OF OPERATION <u>3-21-79</u> <u>4-26-79</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fract. L. Hip</u> <u>Subdural Hematoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>3 18 1979</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Fell at home in bathroom</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>		21i. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Treadway Ct. Brookville Montgomery MD</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. TITLE (SPECIFY) <u>Rep</u> MEDICAL EXAMINER										DATE SIGNED <u>June 29, 79</u>	
EXAMINER'S NAME (TYPE OR PRINT) <u>John S. Rogers</u>										ADDRESS <u>1919 Seminary Road Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>Jul. 2, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Arlington Virginia</u>			
24. FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 3 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Harry K. Brady</u>			
500 University Boulevard, W. Silver Spring, Md.											

200 University Boulevard, N. Silver Spring, Md.
Francis T. Collins
Jul. 2, 1978 Columbia Gardens
Washington, D.C.

John S. Rogers
1919 - 1978

[Faint, illegible handwritten text]

616-44-7518
Larry C. Morgan
June 22, 1978
Washington, D.C.

[Faint, illegible handwritten text]

1978
1978
1978

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15307
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Sophie		MIDDLE G		LAST Mottershead		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH June		DAY 18		YEAR 1979		2b. HOUR P	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 17, 1919		6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR June 21, 1979		2d. HOUR 11:30 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2715 1st Ave Apt 217		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.											
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES X NO		13e. STREET ADDRESS 2715 1st Ave, Apt 217									
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL SHUBINSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA GRODSKY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 054-10-6052		17. INFORMANT ADDRESS MANNY GINSBURG, COUSIN, 10107 DEVERE CRT.		SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>																	
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER						DATE SIGNED June 21, 1979							
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M. D.		ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/22/1979		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN FALLS CHURCH		COUNTY VIRGINIA									
24. FUNERAL HOME NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D.C.		DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>											

1 2 3 0 1



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15308
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE OF DEATH			22. DATE OF DEATH			23. DATE OF DEATH			24. DATE OF DEATH		
August 13 Mugge			June 17 1977			June 17 1977			June 17 1977			June 17 1977			June 17 1977		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 24 HRS.			8. IF UNDER 24 HRS.		
M			W			Sept 10 1908			88 YRS.			21. DATE OF DEATH			22. DATE OF DEATH		
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			71. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. NEVER MARRIED			10. DIVORCED			11. BALTIMORE CITY OR COUNTY OF DEATH		
Florida			U. S. A.			MARRIED			NEVER MARRIED			DIVORCED			Montgomery MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY			14. USUAL RESIDENCE (TYPE OF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. USUAL RESIDENCE (TYPE OF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		
Sil Sp			Holy Cross Hosp			Retired = Civil Engineer			Retired = Civil Engineer			Retired = Civil Engineer			Retired = Civil Engineer		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			13f. STREET ADDRESS		
Fla.			Melbourne			YES X NO			1482 Guava Ave			1482 Guava Ave			1482 Guava Ave		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. SOCIAL SECURITY NO.			18. INFORMANT			19. ADDRESS		
Robert			Caroline			Yes			265-05-3188			Robert H. Mugge			222 Hillsboro Dr.		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			21. IMMEDIATE CAUSE (a)			22. IMMEDIATE CAUSE (b)			23. IMMEDIATE CAUSE (c)			24. IMMEDIATE CAUSE (d)			25. IMMEDIATE CAUSE (e)		
4291			Acute Myocardial Dis			Chronic Myocardial Dis			Yrs.			Yrs.			Yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			Fracture Rt. Hip			Fracture Rt. Hip			Fracture Rt. Hip			Fracture Rt. Hip			Fracture Rt. Hip		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			21. AUTOPSY?			22. AUTOPSY?			23. AUTOPSY?		
None			—			YES			NO X			YES			NO X		
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION			21e. LOCATION			21f. LOCATION		
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			P.M. 5 14 1977			Diggy and Fell at Home			Hillsboro Dr. Sil Sp. Mont Md			Hillsboro Dr. Sil Sp. Mont Md			Hillsboro Dr. Sil Sp. Mont Md		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			21g. LOCATION			21h. LOCATION			21i. LOCATION		
WHILE AT WORK			Home			Hillsboro Dr. Sil Sp. Mont Md			Hillsboro Dr. Sil Sp. Mont Md			Hillsboro Dr. Sil Sp. Mont Md			Hillsboro Dr. Sil Sp. Mont Md		
22a. I certify that I took charge of the remains described above, held an			Autopsy			Inspection			Inquiry			and in my opinion			and in my opinion		
death resulted from			Natural causes			Accident			Suicide			Homicide			Undetermined manner		
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			DATE SIGNED			DATE SIGNED			DATE SIGNED		
Dr. John S. Rogers			M.D. Dep.			MEDICAL EXAMINER			MEDICAL EXAMINER			MEDICAL EXAMINER			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			ADDRESS			ADDRESS			ADDRESS			ADDRESS		
Dr. John S. Rogers			Silver Spring, Maryland			Silver Spring, Maryland			Silver Spring, Maryland			Silver Spring, Maryland			Silver Spring, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. LOCATION			23f. LOCATION		
Burial			6/23/79			Woodlawn Cemetery			Tampa Hillsborough Fla.			Tampa Hillsborough Fla.			Tampa Hillsborough Fla.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE			25e. REGISTRAR'S SIGNATURE		
Warner E. Pumphrey, Inc.			JUN 22 1979			JUN 22 1979			JUN 22 1979			JUN 22 1979			JUN 22 1979		
NAME			ADDRESS			ADDRESS			ADDRESS			ADDRESS			ADDRESS		
Warner E. Pumphrey, Inc.			8434 Ga. Ave.			8434 Ga. Ave.			8434 Ga. Ave.			8434 Ga. Ave.			8434 Ga. Ave.		



6 0 0 2 1 5 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9 1 5 3 0 9															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR							
William		Evans		MULLAN		June		14		1979 5:50P ^M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Caucasian		May 2 DAY 1898 ^{YEAR}		81		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA				Montgomery MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		National Naval Medical Center								U. S. Navy							
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland										Frederick		Frederick		312 North College Parkway			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST				FIRST MIDDLE LAST													
Ambrose B. Mullan				Caroline Evans													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
Yes				1920-50				578 44 3951				Mrs. Robert Tansey See Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Acute Anteroseptal myocardial infarct</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
410 - DUE TO, OR AS A CONSEQUENCE OF (b). <u>Diagnosis Myasthenia Gravis 2yrs</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c).																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 2, 1979, to June 14, 1979, that (I) (we) last saw the deceased alive on June 14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) see the body after death.																	
22b. SIGNATURE				DEGREE				22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				June 15, 1979									
Andrew J. Dutka, M.D.				22e. ADDRESS				National Naval Medical Center, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				June 19, 1979		Arlington National				Arlington Arlington Va.							
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
100 East Church Street				Maryland				JUN 19 1979				Lutney McCready					
Smith, Fadeley, Keeney & Basford Frederick																	

12309

William J. Duffy, M.D.
Chief, Division of Infectious Diseases
National Naval Medical Center
Bethesda, Maryland
20814-5015
Telephone: (301) 434-3511
Fax: (301) 434-3512

June 1, 1997
Dr. William J. Duffy, M.D.
National Naval Medical Center
Bethesda, Maryland
20814-5015
Dear Dr. Duffy:



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 15310 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Albert		NMN		muller				6-28-79	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
male		white		5 16 1893		86		5:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS	
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
Rockville		Potomac Valley Nursing Home		retired		U.S. Gov't			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Kensington				10715 St. Paul Street	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
Frank C. Muller		UNKNOWN		no		579-16-2705		Marie Etta Muller same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- Cardiac arrest		436- Cardiac arrest		436- Cardiac arrest		436- Cardiac arrest		1 hr	
DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (b)		few weeks	
CVA, UTJ, CBS		CVA, UTJ, CBS		CVA, UTJ, CBS		CVA, UTJ, CBS		few years	
DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		19						21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-11-1979 to 6-28-1979, that (I) (we) lost the deceased alive on 6-18-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Frank Westphal		MD		6-28-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED			
Frank Westphal		809 Viers Mill Rd Rockville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		6/28/79		Metropolitan Crematory		Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. DATE REC'D. BY REGISTRAR			
Tyson Wheeler Funeral Home, Inc.		JUL 2 1979		History McCreedy					
1331 Rockville Pike Rockville, Md. 20852									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0121



1951 November 14, 1951
1951 November 14, 1951



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR 115 ME (5))
15M 7/77

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15311

1. DECEASED NAME (TYPE OR PRINT)			FIRST Vera			MIDDLE Viola			LAST Mulligan			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6/15 1979			2b. HOUR 6:19 PM								
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jul 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 6/15 1979			2d. HOUR a. PM								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.											
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 715 Midland Road								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY own home							
13a. STATE --				13b. COUNTY Washington, D. C.				13c. CITY OR TOWN Washington, D. C.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 815 - 18th Street, N. W.							
14. FATHER'S NAME FIRST MIDDLE LAST (Unknown) Price						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES no none						16b. SOCIAL SECURITY NO. 579-50-7830					
17. INFORMANT Edward J. Mulligan-son-S.S. Md.												ADDRESS 715 Midland Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																							
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 6/15/79											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-19-79				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Md Va.											
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.												25a. DATE REC'D. BY REGISTRAR JUN 22 1979				25b. REGISTRAR'S SIGNATURE <i>Anthony J. Brady</i>							
8434 Ga. Ave., S.S. Md.																							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 15312	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
BERTHA EMMA MULLINGS						JUNE 2 1979			4:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		JAN 8 1892		87 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASH. D.C.		U.S.				MONTGOMERY, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		708 RITCHIE AVENUE				HOUSEWIFE		own home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
			MD.			MONT.			SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
JOHN C. KRAMER			IDA DULEY						708 RITCHIE AVE. SPRING, MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			none			579-16-9224			JAMES W. MULLINGS JR. 8608 GREENWOOD AVE. PART 1 MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE											
4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) GENERAL ARTERIOSCLEROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
ATRIAL FIBRILLATION, HISTORY OF											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from OCT. 1962, to JUNE 2, 1979, that (we) last saw the deceased alive on JUNE 2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
James A. Roberts, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			JUNE 2, 1979					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
JAMES A. ROBERTS			8907 GEORGIA AVE. SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			June 5, 1979		Ft. Lincoln		Brentwood Pr. Georges Md.				
24. FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.			JUN 6 1979			History McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 in this form is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					7 9 1 5 3 1 3 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) Lottie F. MULLINIX					2a DATE OF DEATH MONTH DAY YEAR June 5, 1979			2b HOUR 1:45A_M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 10, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland					13b COUNTY Howard		13c CITY OR TOWN Mt. Airy		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Frank Watkins					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fidelia Reed				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-36-3474		17 INFORMANT ADDRESS Robert B. Mullinix, Ijamsville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Pancreas 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6-1-79 , 19____, to 6-5- , 19 79 , that (I) (we) lost saw the deceased alive on 6-4-79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Thomas P. Sloan				DEGREE M.D.				22c DATE SIGNED June 5, 1979	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Sloan, M.D.				22e ADDRESS 9701 Church St., Damascus, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE June 7, 1979		23c NAME OF CEMETERY OR CREMATORY Howard Chapel		23d LOCATION CITY OR TOWN COUNTY STATE Long Corner, Howard, Md.			
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a DATE RECEIVED BY REGISTRAR JUN 7 1979		25b SIGNATURE OF REGISTRAR			

MEDICAL CERTIFICATION



John L. Holmstrom, Director, N.Y.
James J. Hogan, N.Y.
Howard Chapin
John S. Jones, N.Y.
John S. Jones, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE - REGISTRAR									
REG. NO. 9 15314									
1. DECEASED NAME (TYPE OR PRINT) HELEN G MUNYAN						2a. DATE OF DEATH MONTH DAY YEAR 6/6/79		2b. HOUR 6A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 28 1922		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) San Buena Vista Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9917 Hillridge Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Sephus Golden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Mayers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Reuben M. Munyan, Husband. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST 436- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe anoxia, g.I. Bleeding, Hypotension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10400 Conn Ave Kensington					
22a. I certify that (I) (this hospital) attended the deceased from 1972 19____, to 6/6/79 19____, that (I) (two) lost saw the deceased alive on 6/5/79 19____, and that in (my) (two) opinion death occurred on the date and hour and from the causes stated above, (I) (two) (did) (did not) view the body after death.									
22b. SIGNATURE Jeremy Dooke				DEGREE Attending Physician		22c. DATE SIGNED 6/7/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy Dooke				22e. ADDRESS 10400 Conn Ave Kensington					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC.				25a. DATE RECD. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Robert M. Crosby			
5130 WISD. AVK, N. W. WASH, D. C. 20018									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					79 15315 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) HELLEN Faris MYERS					2a. DATE OF DEATH MONTH DAY YEAR 6 24 79					2b. HOUR 8:05 P.M.
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9/17/1899		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS 4400 East West Highway
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda						
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Faris					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Elizabeth Hellen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-84-2412		17. INFORMANT ADDRESS John F. Myers, 7704 Chatham Road, Chevy Chase, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 1749 DUE TO, OR AS A CONSEQUENCE OF: (b) Breast Carcinoma Rt. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 4 months DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Lymphoma - Poorly Differentiated Lymphoma										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 79 , to June 24 , 19 79 , that (I) (we) lost saw the deceased alive on 24 June , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eugene P. Libre MD					DEGREE MD			22c. DATE SIGNED 25 June 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. Libre MD					22e. ADDRESS 10400 Conn. Ave. Kensington MD 20791					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/27/79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, MD					25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>			

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Paris

Female

Canadian

9/17/1999

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U.S.A.

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Robert

Robert

4100 East West Highway

Montgomery Bethesda

Robert

Lee

Paris

Carrie

Elizabeth

William

7704 Graham Road

577-84-3412 John F. Myers, Chevy Chase, Maryland

No

Robert

9/17/99

Rock Creek Cemetery Washington, D.C.

Robert A. Murphy Funeral Home, P.A.

15515

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA G NAGNOWITZ			2a. DATE OF DEATH MONTH DAY YEAR 6 30 79		2b. HOUR 10^{PM}				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR ? ? 1890		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1401 Blair Mill Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST unknown Janofsky				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 132-16-7939B				17 INFORMANT ADDRESS Seymour Nagan; 9308 Inglewood Ct., Potomac Md.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart Disease		years
DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis		"

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/25 , 19 72 , to 6/30 , 19 79 , that (1) (we) last saw the deceased alive on June 4 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Morton W Shapir MD				DEGREE MD		22c. DATE SIGNED 6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton W Shapir MD				22e. ADDRESS 5225 Rock Hill Rd Bethesda			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-79		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Maryland	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels				ADDRESS 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR JUL 3 1979	
						25b. REGISTRAR'S SIGNATURE Horty McBrady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Particular attention should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		15317									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Wallace L. Nahin				2a. DATE OF DEATH MONTH DAY YEAR 6.12.79				2b. HOUR 11:37 PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR June 26 1914		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Con. Engineer				12b. KIND OF BUSINESS OR INDUSTRY Engineer	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9601 Bulls Run Pkwy			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Nahin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Loose							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 388-03-1483		17. INFORMANT ADDRESS Mary L. Nahin (Same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST (ELECTRO-MECHANICAL DISSEMINATION) 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) 3 HRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JUNE 12, 1979 to JUNE 12, 1979 , that (I) (we) last saw the deceased alive on JUNE 12, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas G. Sinderson, MD				DEGREE MD				22c. DATE SIGNED 6-12-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD				22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-15-79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md.			
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A., Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79		15318		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) SARAH I NAUS				2a. DATE OF DEATH MONTH DAY YEAR 6-30-79		2b. HOUR 7:45P M			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2801 Plyers Mill Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Charles H. Jennings				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise M. Coleman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17 INFORMANT Same as above A Rosser L. Nalls (Husband)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Gram Negative Sepsis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>June 18</u> , 19 <u>79</u> , to <u>June 30</u> , 19 <u>79</u> , that (I) <u>we</u> last saw the deceased alive on <u>June 30</u> , 19 <u>79</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did not</u> view the body after death.									
22b. SIGNATURE <u>Barry Hecht</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED July 1, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HECHT				22e. ADDRESS 10620 GEORGIA AVENUE SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/3/79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR JUL 5 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

15319

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Norma Jean Neilson			2a. DATE OF DEATH MONTH DAY YEAR June 25, 1979		2b. HOUR 2:20 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 6, 1935		6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Supply CO.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Allegany 13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 635
14 FATHER'S NAME FIRST MIDDLE LAST George F. Loar			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helena Windeknecht		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-32-1413		17 INFORMANT same as patient's
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC OVARIAN CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 18, 1979 , to June 25, 1979 , that (I) (we) lost saw the deceased alive on June 25, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE George Karp, M.D.		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE KARP, MD		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gdns. Cumberland, Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS Durst Funeral Home, Frostburg, Md. 21532			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Henry McCreedy			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the certificate to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST DALE A NICHOLAS					MONTH DAY YEAR HOUR 6 9 79 4:17P M				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		Caucasian		May 27 1916		63 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Gen. Mechanic		P.G. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?				
13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Pr. Geo. Hyattsville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Marshall Emerson Emerson					FIRST MIDDLE LAST Versa Ethel Winemillow				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
yes WW II					579 01 1415		Elsie M. Nicholas Same as # 13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>lymphangitic spread of tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of prostate</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>4 months</u> <u>3x915</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>April 17</u> , 19 <u>79</u> , to <u>June 9</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>Deborah Goldberg</u>					M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS				
Deborah Goldberg, M.D.					1106 Spring St. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			12 Jun 79		St. Andrews Church Cem		Dillwyn, Virginia		
24 FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert G. Beall Funeral Home					JUN 14 1979		<u>W. S. Sullivan</u>		
9013 Annapolis Rd, Lanham, Md. 20801									

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		79 15321 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
James B. Nicholson, Jr.								June 7, 1979		12 Noon	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		Oct. 6, 1908		70 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital				Ret. Mgr.		Bank			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montg.		Rockville				408 Falls Rd.			
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
James B. Nicholson, Sr.						Mary B. Trail					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
No				577-48-0446		Elizabeth W. Nicholson Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ectopic Neuroblastoma of left testis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1600 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive Metastasis to Brain</u>										Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										1st diagnosed 15 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1: <u>Pneumonia, Right lobe. Anaerobic infection of nose & sinuses. Diabetes. Hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
June 3, 1979		Control of epistaxis, left									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1979</u> to <u>June 7, 1979</u> , that (I) (we) lost the deceased on <u>June 1, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Dino E. Flores M.D.		M.D.		6-8-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dino E. Flores		50W Edmonston Dr Rockville, Md 20858									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		June 11, 1979		Monocacy Cem.		B eallsville Md					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Md.		JUN 15 1979				P. A. Pumphrey					

1 2 3 4 5 6 7 8 9 10 11 12

12/00

June 7, 1979

James

Cambridge 100 N. 100

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USA

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Suburban Hospital

Monte. Rockville

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James D. Nicholson, Jr.

Elizabeth. Victoria Same as 12

Wine L. Fierce

June 11, 1979

Robert A. Fierce

James, P.A. Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

ANIE R. SOLTE 2 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Annie R. Nolte			2a DATE OF DEATH MONTH 6 DAY 14 YEAR 79			2b HOUR 2 0 M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH March DAY 17 YEAR 1888		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Monty Co. Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Air Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b KIND OF BUSINESS OR INDUSTRY —	
13a USUAL RESIDENCE (IF HUSBAND, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Montgomery CITY OR TOWN Fairland				13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS 1374 Old Columbia Rd.	
14 FATHER'S NAME FIRST James LAST Boyer		15 MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Miles LAST Miles					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 213-40-8201		17 INFORMANT John Conifant (son) ADDRESS Rt. 5, Box 63, Mt. Airy, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 4292	DUE TO, OR AS A CONSEQUENCE OF TERMINAL CONGESTIVE HT FAIL	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) CEREBRAL THROMBOSIS	72 HRS.
	(c) DETERIO SOLEPOYIC C.V.D	YRS

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from 9/20 70 to 6/14 79 that (1) we last saw the deceased alive on 6/14 79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) visit the body after death.							
22b SIGNATURE Donald R. Lewis				DEGREE ATTENDING PHYSICIAN		22c DATE SIGNED 6/14/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD				22e ADDRESS OLNEY, MD. 20832			

23a BURIAL, CREMATION, REMOVAL (TYPE)		23b DATE June 16-1979		23c NAME OF CEMETERY OR CREMATORY St. Mark's Ch. Cemetery Fairland Monty-Md		23d LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Arthur Walters		24b ADDRESS 254 Carroll St. N.B.		25a DATE REC'D. BY REGISTRAR JUN 18 1979		25b REGISTRAR'S SIGNATURE Anthony McCready	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 9 9 1 5 3 2 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHRISTINE S. NORCROSS					2a. DATE OF DEATH MONTH DAY YEAR 6-14-79				
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 6 9 87		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7b. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? us		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10 CITY OR TOWN OF DEATH Olney, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3523 Raymond St.	
14 FATHER'S NAME FIRST MIDDLE LAST Albert Cleveland					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cynthia (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. Unknown		17 INFORMANT ADDRESS David Norcross-Son 5327 Allandale Rd. Beth., Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive heart failure 1-2 days (c) Hypertensive Cardiovascular disease several years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral arteriosclerosis + old age									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-10 hrs
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			70a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Feb. 10, 1972, to 6-14-79, that (1) (we) lost the deceased alive on 4-8-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.									
22b. SIGNATURE John R. Spencer, M.D.					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-14-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. SPENCER, M.D.					22e. ADDRESS 337 Compton Ave Laurel, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/18/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C.					25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE R. J. H. H. H.		

1 2 3 4 5 6

CLEARED BY MEDICAL EXAMINER

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Martha Mae Norwood</i>					2a. DATE OF DEATH Month Day Year <i>6 13 79</i>			2b. HOUR <i>6:50 P M</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Sept. 26, 1910</i>			6. AGE (In years last birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>13011 Old Columbia Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>H. Wife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Mont.</i>			13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>13011 Old Columbia Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Edward - Butler</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Etta - Dodson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>214-52-5788</i>		17. INFORMANT Address <i>Bradley E. Norwood, Jr. Same as #13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension + Azotemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diffuse Bone Involvement with fractures, thrombocytopenia, anemia, renal failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 wks.</i> <i>18 mo</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diffuse Bone Involvement with fractures, thrombocytopenia, anemia, renal failure</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr</i> , 19 <i>78</i> , to <i>13 June</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6 June</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Donald E. Dillon MD</i>					DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>14 June 79</i>		
22d. PHYSICIAN'S NAME (Type) <i>Donald E. Dillon, M.D.</i>					22e. ADDRESS <i>Olney, Md. 20832</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>June 16, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Burtonsville</i>			23d. LOCATION (City or Town) (County) (State) <i>Burtonsville Mont Md.</i>				
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>					ADDRESS <i>Laytonsville, Md. 20760</i>			25a. REC'D BY REGISTRAR <i>JUN 18 1979</i>		25b. REGISTERED SIGNATURE <i>[Signature]</i>	

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

115325

1. DECEASED NAME (TYPE OR PRINT) Clara G O'Brien			2a. DATE OF DEATH MONTH DAY YEAR 6 4 79			2b. HOUR 11:50 AM			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 7 1899		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 109 Randolph Road,	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Shorter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nanny M. Simms				Hinwood	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS Mary Nichols-sister-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 76 , to 6/4 , 19 79 , that (I) (we) last saw the deceased alive on 6/4 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ernest S. Oser				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ernest S. Oser, MD.				22e. ADDRESS 10301 Ga. Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Montgomery Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. DATE REC'D. BY REGISTRAR JUN 11 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			
24b. ADDRESS 8434 Ga. Ave., S.S. Md.									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2502



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 3 2 6				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>William</i>			FIRST MIDDLE LAST <i>Oheim</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 6 1979</i>			2b. HOUR <i>10:40 A.M.</i>
3 SEX <i>Female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>July 21 1893</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sligo Gardens Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Sil. Spring</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1716 Republic Road,</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie</i> (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>none</i>		17. INFORMANT ADDRESS <i>William R. Oheim-son- (same as 13e)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic brain syndrome</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <i>1960</i> to <i>6-6</i> , 1979, that (I) (we) last saw the deceased alive on <i>5-31</i> , 1979, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (we) (did) not view the body after death.									
22b. SIGNATURE <i>Eino Magi, M.D.</i>						DEGREE		22c. DATE SIGNED <i>6-6-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EINO MAGI</i>						22e. ADDRESS <i>7600 Carroll Ave., Takoma Park, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-9-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trinity Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Baltimore</i>		COUNTY STATE <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Walter E. Pumphrey, Inc.</i> <i>8434 Ga. Ave., S.S. Md.</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 15327

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
CHARLES ROSS O'NEILL			JUNE 01, 79			08			30			A					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
MALE			CAUCASIAN			JUNE 01, 1979			0			YRS. 0			0 0 35		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND			U.S.						BETHESDA, MONTGOMERY CO. MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BETHESDA			NATIONAL NAVAL MEDICAL CENTER														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
VIRGINIA			FAIRFAX			FAIRFAX			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4117 MIDDLE RIDGE DRIVE					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
MALCOLM ROSS O'NEILL			JUDY MAXINE HESTER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
N/A			NONE			FATHER			ADDRESS SAME AS LINE 13								
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d):			PREMATURE BIRTH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
7651			DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) Premature Labor														
			DUE TO, OR AS A CONSEQUENCE OF														
			(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																	
D G Bair																	
22e. ADDRESS																	
U S Naval Hosp Bethesda, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Burial			6/5/79			Arlington Nat. Cem. Arlington, Va.											
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE			26. REG. NO.			27. REG. NO.					
Everly Funeral Home			Fairfax, Va.			JUN 7 1979											

BP

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U. S. Naval Hospital, Norfolk, Va.

U. S. Naval Hospital, Norfolk, Va.
Arlington Hall, Arlington, Va.
Arlington Hall, Arlington, Va.
Arlington Hall, Arlington, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15328	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Augustus D. Oursler. Sr.				2a. DATE OF DEATH MONTH DAY YEAR June 30, 1979				2b. HOUR A. 12.30 M	
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 12 1888		6. AGE (IN YEARS LAST BIRTHDAY) YRS 90		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.					
10. CITY OR TOWN OF DEATH Burtonsville.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15920 Oursler Road. Burtonsville.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer (Retired).		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland.				13b. COUNTY Montg.		13c. CITY OR TOWN Burtonsville.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Oursler.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Baines.				13e. STREET ADDRESS 15920 Oursler Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 220-34-4668		17. INFORMANT ADDRESS Charles G. Oursler (Son). 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Pulmonary edema - progressive 5-6 days (b) Congestive heart failure 6-7 days (c) Recurrent C.V.A. (Cerebral Thrombosis) Coma 6-7 days PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis, advanced stage, rt. hemiplegia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 7-28-79, to 6-30-79, that (1) (we) lost the deceased alive on 6-24-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.										22c. DATE SIGNED 6-30-79	
22b. SIGNATURE John R. Spencer, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Spencer				22e. ADDRESS 330 Compton Ave. Laurel, Md.							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE Burial July 2-1979		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Montg. Md.					
24. FUNERAL DIRECTOR Robert Walters		24b. DATE REC'D. BY REGISTRAR JUL 6 1979		24c. REGISTRAR'S NAME J. H. H.							

0 5 6 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Wylie Prentice Pack					2a. DATE OF DEATH June 26, 1979		2b. HOUR 3:25 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 20, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, (NIH)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Air Cond-Heating		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7716 Beech Tree Road	
14. FATHER'S NAME William Pack					15. MOTHER'S MAIDEN NAME Ivy M. (not known)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. 2		17. INFORMANT Mrs. Olive Pack Daytona B, F132018					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1729 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Melanoma Metastatic DUE TO, OR AS A CONSEQUENCE OF (c) 2 Years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June, 22, 19 79, to June, 26, 19 79, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June, 26, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not see view the body after death.									
22b. SIGNATURE R.M. Levenson MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. Levenson Jr. MD				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/29/79		23c. NAME OF CEMETERY OR CREMATORY Norwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hearne, Robertson, Texas			
24. FUNERAL DIRECTOR W. W. Chambers Co., Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR JUL 5 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		79 15330 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William W. Pahl					2a. DATE OF DEATH MONTH DAY YEAR 6-3-79			2b. HOUR 5:08 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 30 99		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY Design Engr.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 259 Congressional Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Pahl					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Reich				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Gwendolyn Pahl same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5754 IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Tubular necrosis DUE TO, OR AS A CONSEQUENCE OF (c) Toxemia from liver abscess, ruptured gall bladder APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days 4 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION 5/24/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Liver abscess				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 5/17, 1979, to 6/3, 1979, that (I) (we) last saw the deceased alive on 6/2, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.									
22b. SIGNATURE Sidney J. Cohen, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Cohen, M.D.				22e. ADDRESS 121 Congressional Lane, Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/6/79		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle Village New York			
24. FUNERAL DIRECTOR NAME Tyson Wheelers Funeral Home, Inc. 1331 Rockville Pike Rockville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 7 1979		25b. REGISTRAR'S SIGNATURE L. J. Brady			



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1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 15331

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pierre Pallamary

2a. DATE OF DEATH MONTH DAY YEAR 6/7/79

2b. HOUR 3:10 PM

3 SEX Male

4 RACE white

5 DATE OF BIRTH MONTH DAY YEAR 12 1 1892

6 AGE (IN YEARS LAST BIRTHDAY) 86

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.

10 CITY OR TOWN OF DEATH Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.

12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Translator

12b KIND OF BUSINESS OR INDUSTRY Transportation NIH

13a STATE Maryland

13b COUNTY Montgomery

13c CITY OR TOWN Rockville

13d INSIDE CITY LIMITS? YES ☒ NO ☐

13e STREET ADDRESS 1606 Martha Terrace

14 FATHER'S NAME FIRST MIDDLE LAST John Pallamary

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Bareau

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW I

16b SOCIAL SECURITY NO 089-10-2088

17. INFORMANT ADDRESS Hilda M. Sokol same as 13e

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST

4292

DOUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease

DOUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from about mid 1977 to 6/6/79, that (I) (we) last saw the deceased alive on 6/6/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE H. Montachab M.D. DEGREE

22c DATE SIGNED 6/7/1979

22d PHYSICIAN'S NAME (TYPE OR PRINT) HAMID MONTACHAB, M.D.

22e ADDRESS 6111 Executive Blvd. Rockville MD 20852

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b DATE 6/11/79

23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery

23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.

24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland

25a DATE REC'D. BY REGISTRAR JUN 12 1979

25b REGISTRAR'S SIGNATURE [Signature]

12531



Male
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Maryland Montgomery Rockville
John
Palm
09-10-2028
John W. John and his wife
John

John
Tyson
Rockville Pike
June 1931
John W. John and his wife
John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 1 5 3 3 2			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Heralambas Papaheraklis				6 10 79 10 ⁵⁰ A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		9 16 27		51 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Greece		Greece				Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Adventist Hosp		Cook		Restaurant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md. Mont. Bethesda						4812 Middlesex lane	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
George Papaheraklis		Mary Daniel		No			
16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629			
578-74-5119		George Papaheraklis Same as #13		Respiratory Failure - Collapsed Lung			
				DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Rt. Lung - mediastinum and spinal cord			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5-21-79		Cancer of Lung & difficulty breathing					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. — 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/21/79, 19 to 6-10 1979, that (I) (we) last saw the deceased alive on 6-10 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
A. Shamim MD						6-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
A. SHAMIM		200 Ft. Meade Rd. Laurel, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/14/79		Parklawn Mem. Park		Rockville, Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S NAME	
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				JUN 15 1979		R. J. Brady	

3 2 0 2 1 2 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15333			
1. DECEASED NAME (TYPE OR PRINT) Celinda Paraud				2a. DATE OF DEATH MONTH DAY YEAR June 17-1979			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 3, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PERU		7b. CITIZEN OF WHAT COUNTRY? PERU		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Gabriel's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN CHEVY CHASE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 WILLARD AVE	
14. FATHER'S NAME FIRST MIDDLE LAST JUAN PLENCE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIANA CUBELIEVAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 4/K		17. INFORMANT ADDRESS PAUL PARAUD - HUSBAND - SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma of Breast 6 yrs DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pathologic Fractures of Femurs (Not due to accident)							
19a. DATE OF OPERATION 1974		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilateral Breast Carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from June 17, 1979 to June 17, 1979 , that (I) lost saw the deceased alive on June 17, 1979 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)							
22b. SIGNATURE James W. Egan M.D. DEGREE M.D.				22c. DATE SIGNED 6-17-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Egan M.D.	
22e. ADDRESS 5413 Cedar Ln - Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-18-79		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac MONTGOMERY MD.	
24. FUNERAL DIRECTOR NAME James E. B...		24b. ADDRESS 2222 W. 18th St. N.W. WASH. DC.		25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Henry M. Brady	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18b. Film# G533										STATE OF MARYLAND									
1. FOR STATE REGISTRAR 7-26-79 as										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR									
Gertrude Virginia Parsons										6 24 79 8:50 PM									
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH DAY MONTH YEAR Aug. 8 1922			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4857 Battery Lane									
14. FATHER'S NAME FIRST MIDDLE LAST Strother					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ona Bartlett					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 235 48 7350 17. INFORMANT ADDRESS 6411 Winnepeg Road Bethesda, Md. Mrs. Jack Lefever									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Carcinomatosis (b) Metastatic ductal carcinoma (c) Due to, or as a consequence of: Origin-breast side? 10 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Pneumonia - possible bronchopneumonia																			
19a. DATE OF OPERATION 6/19/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aspiration of lungs - no diagnosis			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22. I certify that I, this physician, attended the deceased from June 12, 1979 to June 24, 1979, that I saw the deceased alive on June 24, 1979, and that in my opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death, so state.)										22a. SIGNATURE George A. Pumphrey M.D. DEGREE 22b. DATE SIGNED 6/24/79									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) George A. Pumphrey										22d. ADDRESS 6911 Washington Road Bethesda, Md. 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/28/79			23c. NAME OF CEMETERY OR CREMATORY Bridgeport Cemetery Harrison Co. West Va.			23d. LOCATION CITY OR TOWN COUNTY STATE										
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, PA BETHESDA, MARYLAND										25a. DATE AND BY REGISTER 25b. REGISTRAR'S SIGNATURE									

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U.S. AIR FORCE

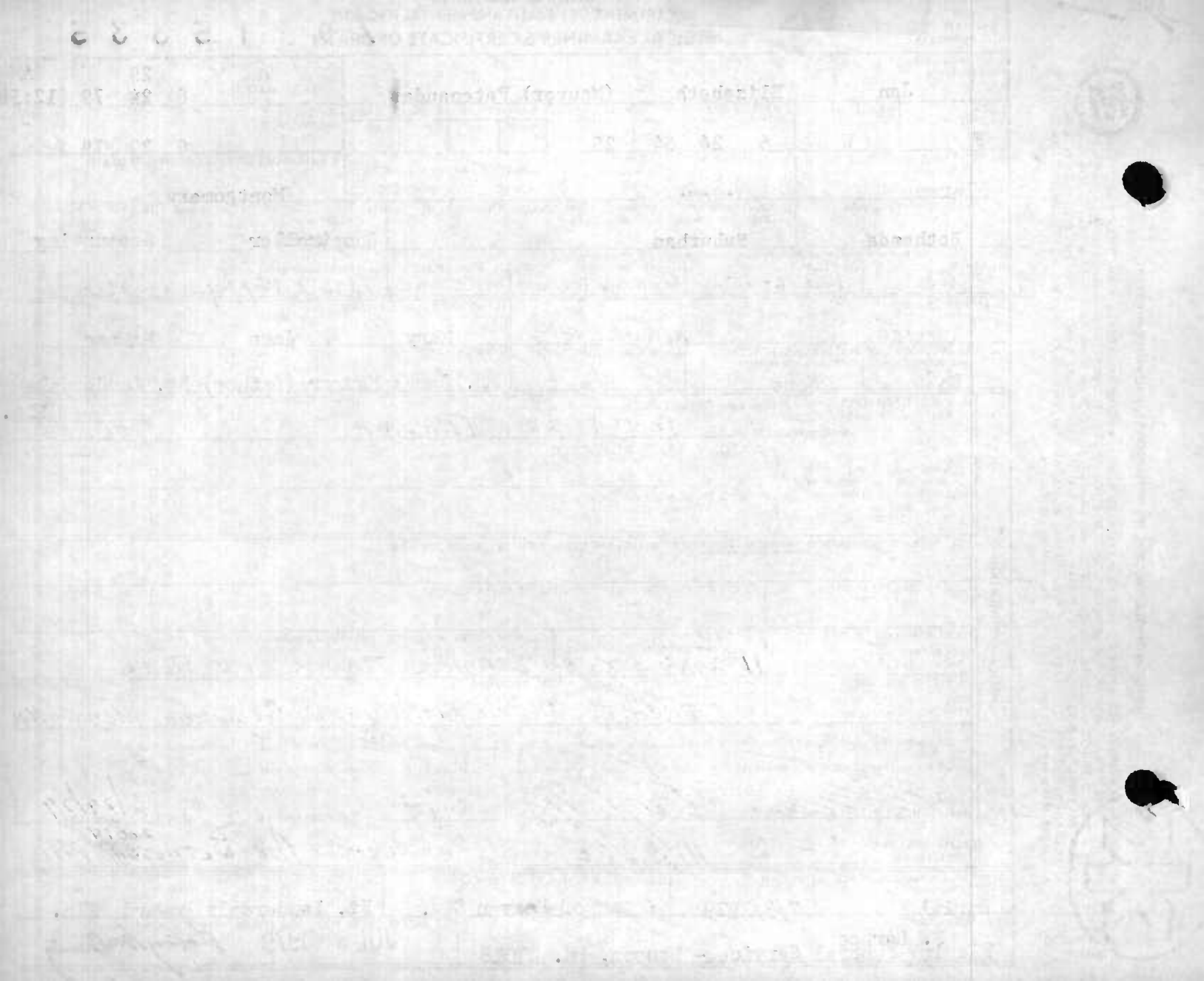
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15335					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jan Elizabeth (Maurer) Patenaude										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 29 1979 2b. DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH DAY YEAR 6 29 1979										2c. HOUR AM PM 12:58					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 24 54		6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptroller				12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. STATE MD										13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GERMANTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18153 Poppywood Lane									
14. FATHER'S NAME FIRST MIDDLE LAST James MAURER										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Maurer															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Mr. James Maurer (father) Ft. Lauderdale																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8120 MULTIPLE TRAUMA Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11:45 PM 6 28 79										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) STRUCK TRUCK IN ROAD					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET										21f. LOCATION CITY OR TOWN COUNTY STATE CLAPPER RD ALBANY NY GERMANTOWN MONT MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE [Signature]										TITLE (SPECIFY) Dept MEDICAL EXAMINER										DATE SIGNED 6/29/79					
EXAMINER'S NAME (TYPE OR PRINT) F. C. MAYLE										ADDRESS 8200 Wisconsin Ave Bethesda MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 7/3/1979		23c. NAME OF CEMETERY OR CREMATORY Queen of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Lauderdale Broward Fla.									
24. FUNERAL DIRECTOR NAME E. Barnes										ADDRESS Fleming Funeral Service - Benson, Md. 21018										25a. DATE REC'D. BY REGISTRAR JUL 3 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



Released to Dr. Bernton per Dr. Bernton
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 5 3 3 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert C Patterson			2a. DATE OF DEATH MONTH DAY YEAR 6 21 79		2b. HOUR 4:05AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 11 04		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Military		12b. KIND OF BUSINESS OR INDUSTRY Army
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5100 Dorset Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Robert W. Patterson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 578-44-1259	17. INFORMANT ADDRESS Hazel B. Patterson Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema, Carcinoma pancreas, generalized arteriosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 05 to 20 June 19 79 , that (I) (we) last saw the deceased alive on 20 June 19 79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Horace Bernton		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 June 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace Bernton		22e. ADDRESS 4743 Bradley Blvd. Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 25, 1979		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Arlington, Va.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.		25a. DATE RECEIVED BY REGISTRAR JUN 25 1979 25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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Sincerely,
[Signature]

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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1. *Abstract*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

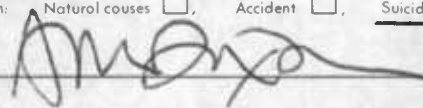
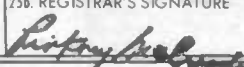
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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15337
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anita Darlene Penny			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 23 19 79			2b. HOUR a. m. 7:00		
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 04- 16 63	6. AGE (IN YEARS) (LAST BIRTHDAY) YEARS MONTHS DAYS 16 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 24 19 79		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18526 Eagle Roost Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student- High School		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY AA	13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Gambille, Maryland 2546 Silver Way		
14. FATHER'S NAME FIRST MIDDLE LAST Harden Harding Penny			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eugenia V. Penny			16. ADDRESS Gambille, Md. Mr. Harden Penny 2546 Silver Way		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-92-1979		17. INFORMANT Harding			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforating gun shot wound of abdomen -handgun DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR ? P.M. 5/23 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 18526 Eagle Roost Dr. Germantown, Montgomery Co., MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) Assistant			DATE SIGNED 5/24/79		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-31-1979		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va	
24. FUNERAL DIRECTOR NAME Herbert E. Nuttre					ADDRESS 3035 W. North Ave		25a. DATE REC'D. BY REGISTRAR MAY 29 1979	
					25b. REGISTRAR'S SIGNATURE 			

10001



THE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C.

1917

ADJUTANT GENERAL

BOD RELEASED WITH BY D. BALL (CORONER)
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 5 3 3 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE M. PERKINS			2a. DATE OF DEATH MONTH DAY YEAR 6 18 79		2b. HOUR 7:45 P.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Apr. 16, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 # UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
13a. STATE Md.		13b. COUNTY Montg		13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST James Crenshaw		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Thompson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16a. SOCIAL SECURITY NO. 108-18-8827		17. INFORMANT ADDRESS Emma Thomas - 22515 White Ferry Rd Dickerson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4414 CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) HUGE ABDOMINAL AORTIC ANEURYSM APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH LEW HRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC HEART + VALVULAR DISEASE					
19a. DATE OF OPERATION 6-18-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL AORTIC ANEURYSM		20a. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6-18-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael G. Seremetis, M.D.		22c. DATE SIGNED 6-18-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL G. SEREMETIS, MD	
22e. ADDRESS 3301 NEW MEX. AV. NW WASH. DC 20016		22f. DATE RECD. BY REGISTRAR JUN 25 1979			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-23-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Md.		24. FUNERAL DIRECTOR NAME George R. Snowden 246 N. Wash St. Rockville, Md.			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9		1 5 3 3 9		REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ernest William Pickett					2a. DATE OF DEATH MONTH DAY YEAR June 5, 1979			2b. HOUR 4:30 P.M.		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 8 29 1917		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 7 15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUSINESSMAN Landscaping		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY CARROLL		13c. CITY OR TOWN WOODBRINE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Ernest W. Pickett					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Claudia Gosnell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2					16b. SOCIAL SECURITY NO. 705-12-5725		17 INFORMANT ADDRESS Marie C. Pickett, Same As #13			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR DYSRHYTHMIA 5698 DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA - OVERWHELMING DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATION of COLON								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 13 days 13 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: BOWEL ADHESIONS										
19a. DATE OF OPERATION 5/23/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATION of COLON				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/23 , 19 79 , to 6/5 , 19 79 , that (I) (we) last saw the deceased alive on 6/5 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sol Shoz				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/5/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL SHOZ				22e. ADDRESS 4805 BEL PRE Rd, ROCKVILLE Md 20853						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-1979		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.				
24 FUNERAL DIRECTOR NAME ADDRESS Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 8 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15340

1. FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anita M. Pohlmann</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 7 79</i>		2b. HOUR <i>10:34 AM</i>						
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 08 00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i>		IF UNDER 1 YEAR MONTHS DAYS <i>YRS</i>		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MICHIGAN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.					
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>10142 DALLAS AVENUE</i>		

14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>578-14-4405</i>		17. INFORMANT <i>FRIEND</i> <i>DOROTHY V. LONG</i>		ADDRESS <i>10144 DALLAS AVE SILVER SPRING, MARYLAND</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>cardiovascular failure secondary</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b): <i>to cerebral vascular thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c): <i>in Arteriosclerotic heart disease -</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>6/8 19 79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/8</i> , 19 <i>79</i> , to <i>6/7</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>6/6</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph M. Solinas</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/7/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH M. SOLINAS</i>		22e. ADDRESS <i>9801 GEORGIA AVENUE, SILVER SPRING, MD.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>6/8/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PROSPECT HILL</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON, D.C.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD.</i>				25a. DATE REC'D. BY REGISTRAR <i>20901 JUN 12 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Julius NMN Poms			2a DATE OF DEATH MONTH DAY YEAR 6-13-1979			2b HOUR 5:55 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR JANUARY 13, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 74	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b KIND OF BUSINESS OR INDUSTRY GROCERY	
13a STATE MARYLAND		13b COUNTY PR. GEORGES		13c CITY OR TOWN HYATTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 721 SOMERSET PLACE	
14 FATHER'S NAME FIRST MIDDLE LAST ABRAHAM POMS				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LIBBY WEINBERG					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-20-8313A		17 INFORMANT ADDRESS NORMA POMS, WIFE, SAME AS No. 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIVER METASTASIS 1629 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6/11 19 79 to 6/13 19 79 , that (I) (we) lost saw the deceased alive on 6/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Kirkland C. Brace				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/13/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND C. BRACE				22e ADDRESS 1100 CARROLL AVE TAKOMA PARK, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 6/15/1979		23c NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTO. MD.			
24 FUNERAL DIRECTOR'S NAME DONALD M. STEIN HEBREW MEMORIAL F.H.				25a DATE REC'D. BY REGISTRAR JUN 18 1979		25b REGISTRAR'S SIGNATURE Henry McCready			
26 ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.									

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 5 3 4 2 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RUDOLPH						POMS		JUNE 19, 1979		1:30A _M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		NOV. 13 1902		76 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
POLAND		U.S.A.				MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVY CHASE		2714 NAVARRE DRIVE						PROPRIETOR		AUTO REPAIRS	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		CHEVY CHASE						2714 NAVARRE DRIVE	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
ABRAHAM		ISAAC		POMS		LIBE		GOLDBERG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
NO		578-46-8021		BESSIE POMS, WIFE, SAME AS No. 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphocytic LYMPHOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 YRS	
2001 DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/13/19 79, to JUNE 19, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/19/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dr. JACK J. RHEINGOLD		2201 L STREET, N.W., SUITE T-6		WASHINGTON, D. C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		6/20/1979		D.C. LODGE CEMETERY		WASHINGTON		D. C.			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
DONALD M. STEIN		HERREW MEMORIAL F.H.		JUN 2 1979		R. J. McQuincy					
232 CARROLL STREET, N.W., WASHINGTON D.C.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR (Lowell)		REG. NO. 15343							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lowell C. PRATT					2a. DATE OF DEATH MONTH DAY YEAR June 6 1979			2b. HOUR 5:50P.M.	
3 SEX Male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 31 1894		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Public Relations	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12803 Conn., Avenue,	
14. FATHER'S NAME FIRST MIDDLE LAST Harry S. Pratt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT ADDRESS Gilbertson-dau-(same as 16e) Lucia Gilbertson			
18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure 5 year duration</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>75</u> , to <u>June</u> , 19 <u>1979</u> , that (I) (we) lost saw the deceased alive on <u>June 1</u> , 19 <u>1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Myron L. Lenkin				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-6-1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myron L. Lenkin, MD.				22e. ADDRESS 2309 Shorefield Road, Wheaton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-8-1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.				25a. DATE OF REGISTRATION June 11 1979 25b. REGISTRATION COUNTY Prince Georges County					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15344	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
		Homer L Prusia					06 04 79		3:45AM		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
male		white		Apr. 28, 1910			69		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Pennsylvania		USA					Montgomery				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney		Montgomery Gen. Hospital					machinist				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Wheaton		YES <input type="checkbox"/> NO <input type="checkbox"/>				14209 Grand Pre Road	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
Glenn		Adie		No		292-10-3081		wife		Best	
								Hannah E. Prusia		same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 5770 Shock										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable pancreatitis										days.	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1979, to June 4, 1979, that (I) (we) last saw the deceased alive on June 3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
J. R. Minarcik, M.D.								6/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
J. R. Minarcik, M.D.		18101 Prince Phillip Drive - Olney, Md. 20832									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		Jun. 7, 1979		Gate of Heaven		Silver Spring		Mont.		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Francis J. Collins		JUN 12 1979				F. J. Collins					
500 University Blvd., W. Silver Spring, Md.											



500 University Avenue, N. W.
Atlanta, Georgia 30303
June 1, 1970
Dear Mr. [Name]
I am writing to you regarding the [Topic]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15345	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST HUGH RABBITT		2a. DATE OF DEATH MONTH DAY YEAR June 18, 1979		2b. HOUR 7:30 A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 1, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self employ			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 451g Chase Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Isaac H. Rabbitt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Harris									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I 577-40-1281		17. INFORMANT Joseph B. Rabbitt		ADDRESS 9804 Wildwood Rd. Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial inf.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>79</u> , to <u>6/18</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Raymond Benack</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-18-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Benack, M.D.		22e. ADDRESS 4115 Colie Dr. Wheaton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 20, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A.		24b. ADDRESS Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>					

BP

June 18, 1972 7:30

June 1, 1971

USA

Silver Springs, Md. The Health Gate Center Farm

Monte. Bethesda

1984 Willard St.

Joseph E. Rabbitt Bethesda, Md.

6-18-72

Raymond Rance, M.D.

June 15, 1972

Robert A. Rabbitt
Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		15346					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paula Rabiner				2a. DATE OF DEATH MONTH DAY YEAR June 28 1979				2b. HOUR 12:35P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 4 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Florida		13b. COUNTY Dade		13c. CITY OR TOWN Miami Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10350 W Bay Harbor Drive	
14. FATHER'S NAME FIRST MIDDLE LAST David Goldberg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 062-05-7885		17. INFORMANT Brother.		ADDRESS Md 20854 Herbert A Goldberg. 9306 Kendale Rd., Potomac			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE 4379 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) HEPATIC ENCEPHALOPATHY; ALZHEIMER'S DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/6 19 75 to 6/28 79, that (I) (we) lost saw the deceased alive on 6/26 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Amiel Segal (FOR J. Rabiner)						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 28, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Amiel Segal M. D.				22e. ADDRESS 2201 L St. N. W. Washington, D. C. 20037					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/2/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. 5130 WISD. AVE., N. W. WASH., D. C. 20016				25a. DATE REC'D. BY REGISTRAR JUL 2 1979		25b. REGISTRAR'S SIGNATURE Barry McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health and mental hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

15347

1. DECEASED-NAME (Type or print) First Middle Last Linda Lee Rafferty			2a. DATE OF DEATH Month Day Year 6 1 79			2b. HOUR 8 a M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 2, 1946		6. AGE (in years lost birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County, Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Ch.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3006 Marshall Street	
14. FATHER'S NAME First Middle Last Edward L. Jenkins			15. MOTHER'S MAIDEN NAME First Middle Last Betty M. Thomas			17. INFORMANT—husband Address 3006 Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 230607341		17. INFORMANT—husband Address William E. Rafferty-Falls Church, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609 INTESTINAL OBSTRUCTION MECHANICAL EXTENSIVE WITH 4 DYS DUE TO, OR AS A CONSEQUENCE OF CHANGRENE, BOWEL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE SURGICAL OPERATIONS FOR INTESTINAL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF OBSTRUCTION (c) GARDNER'S SYNDROME								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/31, 1979 , to 6/1, 1979 , that (I) (we) last saw the deceased alive on 6/1, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William H. Dickson M.D.		22c. DATE SIGNED June 1, 1979		22d. PHYSICIAN'S NAME (Type) Dr. William Dickson		22e. ADDRESS 8320 Old Courthouse Rd. Vienna, VA.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem'l Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia			
24. FUNERAL DIRECTOR Colonial Funeral Home-Falls Church, Va.				25a. REC'D BY REGISTRAR JUN 7 1979		25b. REGISTRAR'S SIGNATURE Hester			



MINISTRY OF HEALTH
DEPARTMENT OF HEALTH

Religion

Age

Place

August 1, 1944

Cheney

Female

Montgomery County

U.S.A.

Virginia

and home

Household

Suburban

Residence

xx 2003 Marshall Street

Patrick Kelly St.

Virginia

Thomas
3006 Harrison St.

Henry

James

Robert

William M. Kelly - Kelly Chapel, Va.

2003 Kelly

June 1, 1945

2003 Old Courthouse Rd. Virginia, Va.

Dr. William D. Kelly

Kelly Chapel, Virginia

June 1, 1945

JUN 1 1945

Colonial Funeral Home - Kelly Chapel, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Neil Rall			2a DATE OF DEATH MONTH DAY YEAR June 29 1979			2b TIME OF DEATH HOURS MIN 7:15 P.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 24 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens N.H.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD			13c COUNTY Montgomery		13d CITY OR TOWN Kensington		13e STREET ADDRESS 3947 Baltimore		13f INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Samuel PLATT			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Deere							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. None		17 INFORMANT Joseph E. Rell		ADDRESS 3947 Baltimore, Md				
18 CAUSE OF DEATH Enter only one cause per line for (1) (2) (3) (4) (5) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Cardiac degenerative heart (b) Due to OR AS A CONSEQUENCE OF Atherosclerotic Cardiovascular Disease (c) Due to OR AS A CONSEQUENCE OF Approximate interval between onset and death 8 years									PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from August 27, 1977, to June 29, 1979, that (1) (we) lost saw the deceased alive on August 13, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Raymond Aravinski, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-29-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Aravinski, M.D.			22e. ADDRESS 3720 Farragut Ave. Ken. Md. 20157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6/30/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suillus, P.C. Md			
24. FUNERAL DIRECTOR NAME W.H. Chambers			ADDRESS 8605 2nd Ave. S.S.			25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. REGISTRAR'S SIGNATURE Hester M. Hester		

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25. 11. 1971

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$$f(x) = 0.5x^2 - 0.25x^3$$

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3, and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ALFRED LEON RAPHAEL			June 19, 1979			11:37AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	WHITE	March 7, 1909	70 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
New York			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
BETHESDA			The Clinical Center, NIH			MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Maryland			Montgomery Silver Spr.			Dentist		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY		
13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2817 Village Lane			US Military		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
Aaron			Raphael			Henrietta		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		
Yes			WWII			Mrs. Ethel M. Raphael (same as above)		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Hepatocellular carcinoma</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>June 19</u> , 19 <u>79</u> , to <u>June 19</u> , 19 <u>79</u> , that (he) (she) (it) saw the deceased alive on <u>June 19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (do) view the body after death		22b. SIGNATURE <u>Richard Bromer, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-19-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard Bromer</u>		22e. ADDRESS <u>National Institutes of Health Clinical Center, Bethesda, Md. 20205</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		6-21-79		Ft. Lincoln		Brentwood, P. G. Maryland	
24. FUNERAL DIRECTOR NAME		1170 Rockville Pk. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Mem. Chapels, Rockville, Md.				JUN 25 1979		<u>Anthony McCreedy</u>	

BP

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UNION

WINTER

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15350

1. DECEASED NAME (TYPE OR PRINT) XXXXX AGATINA RAPISARDI		2a. DATE OF DEATH MONTH DAY YEAR 6-5-79		2b. HOUR 4P M
3. SEX FEMALE	4. RACE W HITE	5. DATE OF BIRTH MONTH DAY YEAR 4 4 89		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY PRINCE GEO.	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST FERDINANDO PATANE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELA ABBATE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 052-09-3536		17. INFORMANT ADDRESS SALVATORE RAPISARDI SAME AS 13 SON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>2 years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>1975</u> to <u>5 June</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5 June</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE <u>Walter E. Goetz</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6 June 79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZEL MD		22e. ADDRESS 2309 Shorefield Road Wheaton MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 6/8/79	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REGD. BY REGISTRAR JUN - 2 1979		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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U C C I



Handwritten signature or text at the bottom left.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 15351	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH		
FIRST MIDDLE LAST <i>Dorothy M. Reid</i>			ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>June 10, 1979</i>		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
<i>F</i>	<i>W</i>	MONTH DAY YEAR <i>June 1 07</i>	LAST BIRTHDAY <i>72 YRS.</i>	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<i>Pa.</i>		<i>U. S. A.</i>		<i>Montgomery, Md.</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
<i>Sil. Spg.</i>		<i>Holy Cross Hosp.</i>		<i>Retired Bookkeeper</i>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
<i>Md.</i>		<i>Montg.</i>		<i>Sil. Spg.</i>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST <i>Walter Thompson</i>		FIRST MIDDLE LAST <i>Gertrude Steinmetz</i>		<i>578-14-6452</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:	
<i>No</i>		<i>Wm. Reid Dr., Silver Spr., Md.</i>		IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
<i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
<i>None</i>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<i>John S. Rogers, M.D.</i>		<i>Medical Examiner</i>		<i>June 10, 1979</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
<i>John S. Rogers</i>		<i>Silver Spring, Md.</i>		<i>Burial</i>	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<i>6/13/79</i>		<i>Parklawn Cemetery</i>		<i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>Warner E. Pumphrey, Inc.</i>		<i>JUN 13 1979</i>		<i>John S. Rogers</i>	
ADDRESS					
<i>8434 Ga. Ave.</i>					
<i>Sil. Spr., Md.</i>					

1000

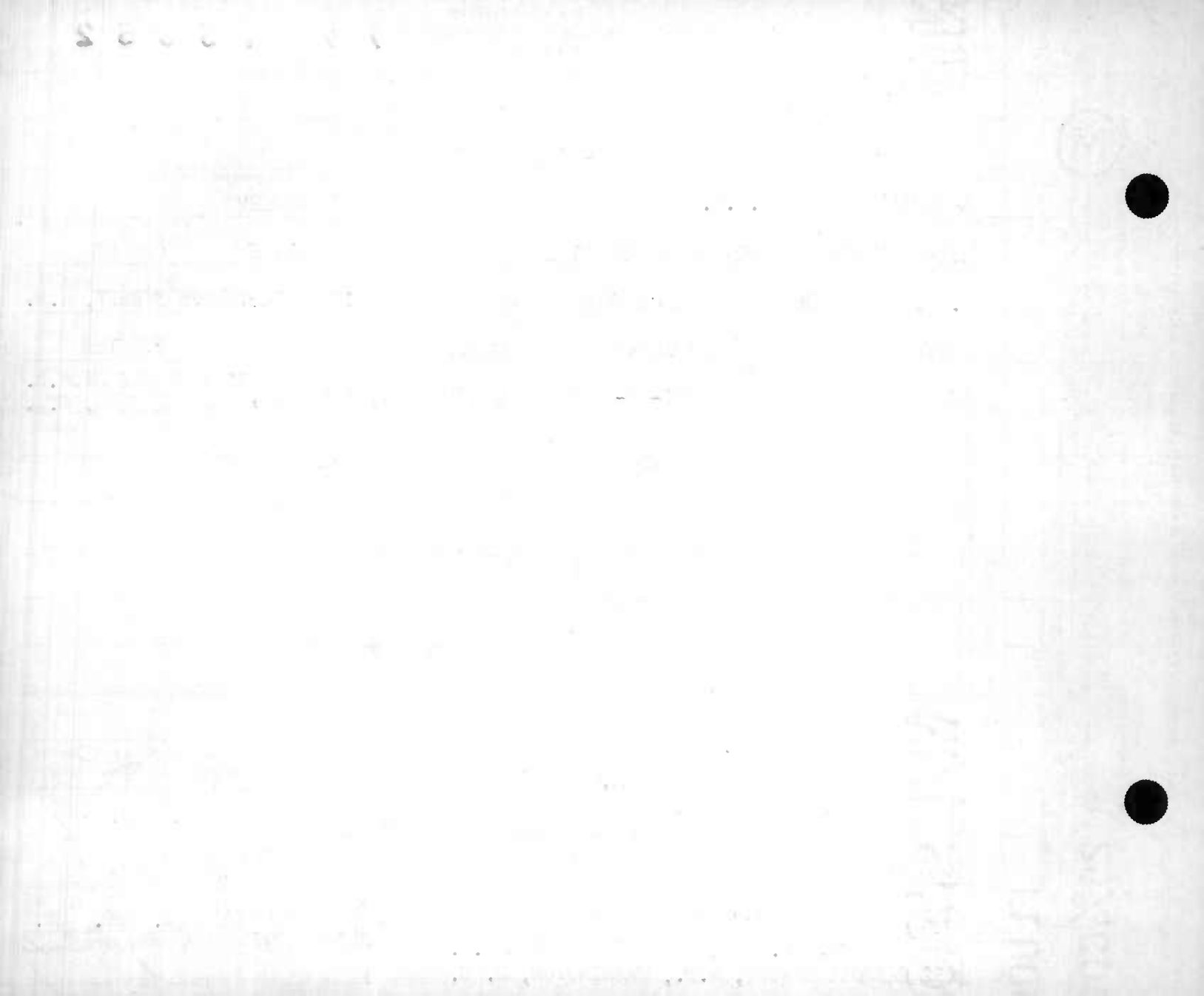
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15352	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				2b. HOUR		
FIRST MIDDLE LAST Sylvia O Rein					MONTH DAY YEAR 6-02-79				7:45 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		WHITE		MONTH DAY YEAR APRIL 3, 1909		70 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
AUSTRIA		U.S.A.				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL				HOUSEWIFE		OWN HOME			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
D. C.			NONE		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1439 OGLETHORPE STREET, N.W.		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST DAVID ORLEANS					FIRST MIDDLE LAST BELLA FENSTER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
NO			577-05-6835		LUSSIA REIN, DAUGHTER,			1708 EVARTS ST. N.E. WASHINGTON, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIOGENIC Shock										2 HRS	
410 - DUE TO, OR AS A CONSEQUENCE OF										7 d.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 5/27/79, 19, to 6/2, 1979, that (1) (we) lost saw the deceased alive on 5/26/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Max G. SHERER M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/2/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
MAX G. SHERER M.D.						800 Pershing Dr. Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			6/4/1979		BNAI ISRAEL CONGREGATION			OXON HILL PR. GEO. MD.			
24. FUNERAL DIRECTOR NAME						25a. DATE REGISTERED			25b. REGISTRAR'S SIGNATURE		
DONALD M. STEIN HEBREW MEMORIAL F.H.						JUN 5 1979			[Signature]		
232 CARROLL STREET, N.W., WASHINGTON, D. C.											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR		7 9 1 5 3 5 3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jean L. Rice			2a. DATE OF DEATH MONTH DAY YEAR JUNE 29, 1979
3 SEX Female			2b. HOUR 1:50 A.M.
4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Aug. 20, 1908	6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Takoma Park		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research	
13a. STATE Florida		13b. CITY OR TOWN Sanibel	
14 FATHER'S NAME FIRST MIDDLE LAST Not available		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available Meredith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-07-8264	
17. INFORMANT Donald K. Rice, Bethesda, MD 20034		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic malignancy DUE TO, OR AS A CONSEQUENCE OF (c) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 79 6/29 79	
22a. I certify that (1) this hospital attended the deceased from 19 79 to 6/29 79 , that (1) (we) last saw the deceased alive on 6/29 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Lewis H. Dennis, M.D.		22c. DATE SIGNED 6/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 831 University Boulevard, East, #35 Silver Spring, Maryland 20903	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-79	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 9 1979	
25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

BP

(M)

Non-Resident

University of Washington

Department of Biology

Seattle, Washington

Box 355060

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(M)

Handwritten signature

University of Washington
Box 355060
Seattle, Washington 98195

10-11-1964

Department of Biology

University of Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15354	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret M. Richards						2a. DATE OF DEATH MONTH DAY YEAR June 24 '79		2b. HOUR 1:40p.m.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 23 1886		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 93 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11901 Georgia Ave., Wheaton,			
14. FATHER'S NAME FIRST MIDDLE LAST Evans				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 214-74-4729		17. INFORMANT ADDRESS 21401 Peach tree St. Clarksburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE AND CARDIAL ARREST 4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION (c) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PARKINSON'S DISEASE, SLIPPER HIP PINNING, BASTARD SUTURE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from MAY 24 1979 to JUNE 24 1979 , that (I) (we) lost saw the deceased alive on 6/23 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan R. Vinitzky MD										22c. DATE SIGNED 6/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. VINITZKY										22e. ADDRESS 12105 DARNESTOWN RD. GAITHERSBURG MD. 20878	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June		23c. NAME OF CEMETERY OR CREMATORY Ft. Snelling Nat. Cem. Minneapolis Hennepin Minn.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Rosabell Sandison		316 E. Diamond Ave., Gaithersburg, Md.		25a. DAY RECEIVED BY REGISTRAR JUN 28 1979		25b. DAY RECEIVED BY REGISTRAR July 1979					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Lee Ritter					2a. DATE OF DEATH MONTH DAY YEAR June 24, 1979			2b. HOUR 10:30 A.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 6, 1955		6 AGE (IN YEARS LAST BIRTHDAY) 23 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Prince Geo. Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Prince Geo. Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5003 Gunther St.	
14 FATHER'S NAME FIRST MIDDLE LAST James J. Ritter					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby - Ritter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS Mrs. Virginia M. Ritter, Wife (same as above)						
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Central respiratory arrest</u> 2040 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute lymphoblastic leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 23</u> , 19 <u>79</u> , to <u>June 24</u> , 19 <u>79</u> , that <u>X</u> (we) lost saw the deceased alive on <u>June 24</u> , 19 <u>79</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) did <u>X</u> (not) view the body after death.										
22b. SIGNATURE Richard Bromer, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/24/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Bromer					22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Wash. Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland-Prince Geo. Co.-Md.				
24. FUNERAL DIRECTOR NAME Chambers Funeral Home-Riverdale, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready			

1. 2. 3. 4. 5. 6. 7.




 1 - FOR
STATE
REGISTRAR

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15356

1. DECEASED NAME (TYPE OR PRINT) WILLIAM M. ROBBINS JR.			7a. DATE OF DEATH MONTH DAY YEAR 6-20-79			7b. HOUR 6:30 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Feb 19-1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YEARS	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montgomery Co. Md.		7d. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUMMARY, GIVE STREET ADDRESS) Washington Adventist Hosp -		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Builder	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. STREET ADDRESS 1404 Queensberry Rd. Hyattsville	
14. FATHER'S NAME FIRST MIDDLE William M. Robbins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary Hilke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 169-07-2139		17. INFORMANT Name Hilda M. Robbins		17b. ADDRESS (13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Upper GI Bleeding 1890 DUE TO, OR AS A CONSEQUENCE OF (b) Stress Ulcer Post Op. DUE TO, OR AS A CONSEQUENCE OF (c) Hypernephroma At Kidney Post op APPROXIMATE INTERVAL BETWEEN CAUSE 1 AND DEATH 1 day unknown 1 wk							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Post op Eu Blac resection At Kidney Venacava 20 prior to admission.							
19a. DATE OF OPERATION 6-12-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hypernephroma At Kidney		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. Smith				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Smith				22e. ADDRESS 831 University Blvd E S11 Spr Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE June 22-1979		23c. NAME OF CEMETERY OR CREMATORY George Washington Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Ridge Rd. P. Lee. Md.	
24. FUNERAL DIRECTOR'S NAME Arthur Walters		24b. ADDRESS 254 Green St. N.Y. N.Y.		25. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady	

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15357 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR 1:00 P.M.						
Leonard		Gilbert		Rosenbaum		Rosenbaum		6/4		19		79												
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR 12:30 P.M.				
Male		White		Mar. 29, 1922		5 YRS.						6/4		19		79								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.												
New York				USA																				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY								
Silver Spring				1001 Silver Spring Avenue, #1014								Stock person				Auto parts								
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
Maryland										Montgomery		Silver Spring				1001 Silver Spring Avenue, #1014								
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																			
Harry					Rosenbaum					Ida					Marton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT														
yes					?					unobtainable					11403 Queens Blvd. Swartz Brothers Funeral Home N.Y.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
None																								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
None																								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy MEDICAL EXAMINER														DATE SIGNED 6/4/79						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																				
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE												
Burial				6-6-1979				New Montefiore				Pine Lawn Suffalk N.Y.												
24. FUNERAL DIRECTOR NAME ADDRESS																		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.																		JUN 8 1979		History McCreedy				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OF
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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MEXICO EXAMINER, TORTOLERO, ETC.

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NEW YORK, N.Y. 10001

LEAVE OF ABSENCE, 10001

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) GLADYS MARTIN ROWLAND			2a DATE OF DEATH MONTH 6 DAY 13 YEAR 79			2b HOUR 6:30 P.M.			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH 7 DAY 15 YEAR 1892		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7 IF UNDER 1 YEAR MONTHS 11 DAYS 11 HOURS 11 MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) SO. INDIA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALTHEA WOODLAND N.H.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MISSIONARY		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a STREET ADDRESS				
13a STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN Upper Marlboro		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS 11409 Maryvale Road	
14 FATHER'S NAME FIRST LOUIS MIDDLE MARTIN LAST Mellora					15 MOTHER'S MAIDEN NAME FIRST Clough MIDDLE XXXXXXXXXX LAST XXXXXXXXXX				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 363-38-0702		17 INFORMANT ADDRESS 11409 MARYVALE RD. UPPER MARLBORO MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC VASCULAR DISEASE 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) OSTEOMYELITIS RIGHT HIP									
19a DATE OF OPERATION June 18, 1975		19b CONDITION FOR WHICH OPERATION WAS PERFORMED OSTEOMYELITIS RIGHT HIP				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET 217 UNIVERSITY BLVD E. SILVER SPRING MD		CITY OR TOWN SILVER SPRING		COUNTY MONTGOMERY	
22a I certify that (I) (this hospital) attended the deceased from June 18, 1975 to June 13, 1979 , that (I) (we) last saw the deceased alive on June 13, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Bernard A Fitzgerald M.D.				DEGREE M.D.				22c DATE SIGNED 6-13-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A FITZGERALD				22e ADDRESS 217 UNIVERSITY BLVD E. SILVER SPRING MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6-18-79		23c NAME OF CEMETERY OR CREMATORY Mt. Ever-Rest Nat Park		23d LOCATION CITY OR TOWN Kalamazoo, Michigan		COUNTY MICHIGAN	
24 FUNERAL DIRECTOR NAME Robt E Wilhelm				ADDRESS 4308 Suitland Rd., Suitland, Md.		25a DATE REC'D. BY REGISTRAR JUN 19 1979		25b REGISTRAR'S SIGNATURE Henry McCreedy	

6 2 0 0 1 7 4 1



RECEIVED





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 1 5 3 5 9

1. DECEASED NAME (TYPE OR PRINT) BARBARA A. RUIZ		2a. DATE OF DEATH MONTH 6 DAY 10 YEAR 79		2b. HOUR 10:50 A.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH JULY DAY 6 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA	7b. CITIZEN OF WHAT COUNTRY? CUBA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD.
10. CITY OR TOWN OF DEATH Bethesda, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12707 BUSHEY DRIVE
14. FATHER'S NAME FIRST JOSE MIDDLE LAST GIL		15. MOTHER'S MAIDEN NAME FIRST JUANA MIDDLE LAST SANTANA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 267-29-1546		17. INFORMANT ESTELA GUILARTE ADDRESS SAME AS 13 DAUGHTER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from June 6, 1979 , to June 10, 1979 , that (I) (we) lost saw the deceased alive on June 9, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE M. R. Cascard		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/10/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IGUEL R CASCARDO		22e. ADDRESS 12400 BOBINK CT POTOMAC, Md 20854		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/12/79	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION STREET CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		23e. DATE REC'D. BY REGISTRAR JUN 12 1979		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE P. J. H. H. H.		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



4 5 0 0 1

20 10 10 10

1906

JULY

WHITE

FEMALE

COLO

COLO

HOUSEWIFE

18707 SUSHEV DRIVE

SILVER SPRING

MONTGOMERY

MARYLAND

SANTANA

JUANA

GTI

1986

DAUGHTER

NAME AS IS

ESTELA CRISTIANE

187-28-1246

NO

STATE OF MARYLAND

FRANCIS J. COLLINS

500 UNIVERSITY W. SILVER SPRING MD. 20901

SILVER SPRING

MD

JUN 2 1979

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. PRESTON ST. BALTIMORE, MD. 21201. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15360 REG. NO.	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathleen Mercer Russ.										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6-17 1979 2b. HOUR 11 A.M.	
3. SEX Female.	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1914	6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-17 1979 2d. HOUR 5:30 P.M.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher.		12b. KIND OF BUSINESS OR INDUSTRY			
10. CITY OR TOWN OF DEATH Silver Spring.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 714 Sligo Ave. S. S. Md.				12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher.					
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Sprg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 714 Sligo Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Grayson H. Mercer.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Grove.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 215-20-3533		17. INFORMANT ADDRESS William F. Russ. (13 e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon & Abdominal Metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Richard L. Whelton</u>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED June 17, 1979			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON				ADDRESS 700 Bull Ave College Park Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Sheddenburg Pk. Md.		23e. STATE Md.			
FUNERAL DIRECTOR <u>Arthur Walters</u>		23f. ADDRESS 207 Carroll St. N.W.		23g. DATE JUN 19 1979		23h. REGISTERED SIGNATURE <u>Arthur Walters</u>					

U O U C

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Said Salim Saah		2a. DATE OF DEATH MONTH DAY YEAR 6-7-79		2b. HOUR 7:21 A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 5, 1924	
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PALESTINE		7b. CITIZEN OF WHAT COUNTRY? JORDAN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		10. CITY OR TOWN OF DEATH TAKOME PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPET AND FURNITURE CLEANER		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS 13401 PARKLAND DRIVE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST SALIM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIAM AWAD		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
17. SOCIAL SECURITY NO. 220-60-5254		18. INFORMANT GEORGETTE S. SAAH		19. ADDRESS SAME AS 13 WIFE	
20. CAUSE OF DEATH (Enter only one cause per 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629 DUE TO, OR AS A CONSEQUENCE OF (c)		21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
24a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE	
25a. I certify that (1) this hospital attended the deceased from April 12, 1979 to June 7, 1979 , that (1) (we) lost him 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.		25b. SIGNATURE Benjamin A. Collins, MD DEGREE		25c. DATE SIGNED 6-7-79	
26a. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin A. Collins, MD		26b. ADDRESS 3720 Fawcett Ave. Rockville, MD 20850		26c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		27b. DATE 6/9/79		27c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	
28a. FUNERAL DIRECTOR FRANCIS J. COLLINS		28b. DATE REC'D. BY REGISTRAR JUN 12 1979		28c. REGISTRAR'S SIGNATURE [Signature]	
29a. ADDRESS 100 UNIV. BLVD., W., SILVER SPRING, MD. 20901		29b. COUNTY MONT		29c. STATE MD.	

DATE: 10-10-68
TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]
[Illegible text block]

[Illegible text block]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 5 3 6 2				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAE N. Samuels					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 6 8 79 2:45 PM				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9 1 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS 80		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13e. STREET ADDRESS 11810 Mentone Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Neiman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Taube Rotterdam					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 125-30-9442		17. INFORMANT ADDRESS Mrs. Evelyn Robbins, 11810 Mentone Rd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1430 UNDIFFERENTIATED CARCINOMA OF LEFT PAROTID GLAND DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. ORGANIC BRAIN SYNDROME. Maturity onset DEMENTIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 4/7 19 78 to 6/8 79, that (2) we saw the deceased alive on 6-8-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE OF ATTENDING PHYSICIAN JOEL A. REISKIN, M.D.						22c. DATE SIGNED 6-8-79		22d. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. REISKIN, M.D.						22f. ADDRESS 809 VEARS MILL RD, ROCKVILLE, MD 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		23d. LOCATION CITY OR TOWN COUNTY STATE Valhalla, N. Y.			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg, 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy			

BP

S o c i e t y



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 1 5 3 6 3				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Barbara Ann Saunders					2a. DATE OF DEATH MONTH DAY YEAR 6-14-79			2b. HOUR 9³⁵ A M	
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR May 6 1937		6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS 7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Prince Georges		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12514 Kadanugh Lane	
14 FATHER'S NAME FIRST MIDDLE LAST George William Wright, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Mae Scratchfield				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-58-8358		17 INFORMANT ADDRESS Richard E. Saunders (Same as 13e)					
18 CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
5733 } DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic failure								2 weeks	
} DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism hepatitis								5 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Alcoholism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from Jan 13 1979 to 14 June 1979 , that (I) (we) last saw the deceased alive on 13 June 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Eric Alving, M.D. DEGREE MD.						22c. DATE SIGNED 6/14/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. ERIC ALVING	
22e. ADDRESS 3327 Superior Lane Bowie 20715									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-17-79		23c. NAME OF CEMETERY OR CREMATORY Mannington Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Marion VA.			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy	

6 5 4 3 2 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 3 6 4	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Max Saunders					2a. DATE OF DEATH June 15, 1979			2b. HOUR 1:25 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH October 6, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Tailoring			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10266 Arizona Circle				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda							
14. FATHER'S NAME FIRST MIDDLE LAST N/A					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-48-3979		17. INFORMANT ADDRESS William Saunders (Same as # 13)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, RUL recurrent, gram Neg organism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute blast cell leukemia Type undetermined,</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Insufficiency</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/79 11/78 10/78	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHF, complete Heart Block</u>											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) <u>the hospital</u> attended the deceased from <u>11-17-78</u> , 19____, to <u>6-15-79</u> , 19____, that (1) <u>last</u> saw the deceased alive on <u>6-14-79</u> , 19____, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>did not</u> view the body after death.											
22b. SIGNATURE <u>J B Patrick III MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. B. PATRICK III M. D.					22e. ADDRESS 9221 COLESVILLE ROAD, SILVER SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/17/1979		23c. NAME OF CEMETERY OR CREMATORY B'NAI ISRAEL CONGREGATION			23d. LOCATION CITY OR TOWN COUNTY STATE OXON HILL, P. G. MD.			
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W. WASHINGTON, D. C.					25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>				

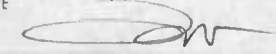



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL SCHILLER					2a DATE OF DEATH MONTH DAY YEAR JUNE 26, 1979				
3 SEX MALE					4 RACE White				
5 DATE OF BIRTH MONTH DAY YEAR 7 9 1898					6 AGE (IN YEARS LAST BIRTHDAY) 80				
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Pennsylvania					7b CITIZEN OF WHAT COUNTRY? U.S.A.				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD				
10 CITY OR TOWN OF DEATH Bethesda					11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Bethesda Health Center				
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b STATE MARYLAND					12c CITY OR TOWN SILVER SPRING				
13a INSIDE CITY LIMITS? YES					13b STREET ADDRESS 11235 OAK LEAF DRIVE				
14 FATHER'S NAME FIRST MIDDLE LAST ABRAHAM SCHILLER					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH (UNKNOWN)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b SOCIAL SECURITY NO. 578-05-8087				
17 INFORMANT ADDRESS MRS. BETTY LESSER, 12603 Laurie Drive, S. S. Md.									
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19				
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 1925 , 19____, to 6/26/79 , 19____, that (I) (we) last saw the deceased alive on 6/22/79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE 					22c DATE SIGNED 6/26/79				
22d PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKAGUL MD					22e ADDRESS 7425 Arlington Rd Bethesda Md				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b DATE 6/28/1979				
23c NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY					23d LOCATION CITY OR TOWN COUNTY STATE ADELPHI PR. GEO. MD.				
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL F.H. NAME ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D. C.					25a DATE REC'D BY REGISTRAR JUL 2 1979				
25b REGISTRAR'S SIGNATURE 									

C O C C

104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-

202402

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200

- 1 -



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 15366

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
RAYMOND C. SCHMIDT, SR.					JUNE	10	1979		10:05PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	JULY 23, 1908		70	MONTHS		DAYS		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
CONNECTICUT		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL		SALES MANAGER		SPERRY RAND CORP.			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS					
MARYLAND		MONTGOMERY KENSINGTON		2707 McCOMAS AVENUE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
SIGMUND SCHMIDT		AUGUSTA WERNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		587-05-5873		SON		18315 ALL SPICE DR. RAYMOND C. SCHMIDT, JR. GERMANTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
410- DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerosis heart disease</i>		4 days							
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive, or above, (I) (we) (did not view the body after death).		19 <i>6/10</i> to <i>6/10</i> 19 <i>79</i>		that (I) (we) lost and that (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<i>Myron L. Lenkin</i>						<i>6/11/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
MYRON L. LENKIN, M.D.		2309 Shorefield Rd. Wheaton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		6/14/79		ST. JOHN'S CHURCH CEM.		FOREST GLENN MONTGOMERY MD.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS		JUN 12 1979		<i>Francis J. Collins</i>					
500 UNIV. BLVD., W. SILVER SPRING, M.D. 20901									

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 3 6 7

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Mary</i> MIDDLE <i>Margaret</i> LAST <i>Schmittou</i> <i>Mary M. Schmittou</i>			2a. DATE OF DEATH MONTH <i>6</i> DAY <i>8</i> YEAR <i>79</i>			2b. HOUR <i>11:15 A</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>8</i> DAY <i>12</i> YEAR <i>52</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Bethesda, Montgomery Co. MD.</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. CITY OR TOWN <i>Montgomery</i> 13c. CITY OR TOWN <i>Bethesda</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4841 Crescent Street</i>					
14. FATHER'S NAME FIRST <i>Patrick</i> MIDDLE <i>---</i> LAST <i>Riordan</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Ellen</i> MIDDLE <i>C.</i> LAST <i>Connor</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579-28-3870</i>		17. INFORMANT ADDRESS <i>Gill V. Schmittou, Same as #13.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>> 5 years</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Right upper lobe infiltrate.</i>											
19a. DATE OF OPERATION <i>NA</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NA</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <i>---</i> A.M. <i>---</i> MONTH <i>---</i> DAY <i>---</i> YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>---</i> CITY OR TOWN <i>---</i> COUNTY <i>---</i> STATE <i>---</i>		21g. I certify that (1) (the hospital) attended the deceased from <i>September 19 75</i> to <i>6/8/79</i> , that (1) (the) last saw the deceased alive on <i>6/8/79</i> and that in my (1) (my) opinion death occurred on the date and hour and from the causes stated above, (1) (and) (did) (did not) view the body after death.					
22a. SIGNATURE <i>Earle B. Thompson MD</i>				DEGREE <i>---</i>				22c. DATE SIGNED <i>6/8/79</i>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Earle B. Thompson, M.D.</i>				22d. ADDRESS <i>6111 Executive Blvd, Rockville, MD 20852</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/11/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION CITY OR TOWN <i>Silver Spring</i> COUNTY <i>Maryland</i> STATE <i>---</i>					
24. FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons, Inc.</i> ADDRESS <i>5130 Wis. Ave., NW Washington, D.C. 20016</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 5 3 6 8 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) MARIE E. SCHNEIDER					2a. DATE OF DEATH MONTH DAY YEAR 6 9 79					2b. HOUR 8:55 PM
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1917		6. AGE [IN YEARS LAST BIRTHDAY] 61 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STREET ADDRESS 46 Orchard Dr.					
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Owen Weaver			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Ellsworth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-3872		17. INFORMANT ADDRESS Philip B. Schneider Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pseudomonas Pneumonia</u> 4912 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> 20 yr (c) <u>Chronic Bronchitis</u> 20 yr DUE TO, OR AS A CONSEQUENCE OF PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>79</u> , to <u>—</u> , 19 <u>—</u> , that <u>X</u> (we) lost saw the deceased alive on <u>6/9/79</u> , 19 <u>—</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <u>G. Stuart Scott</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-9-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott				22e. ADDRESS Bethesda, Md. 10401 Old Georgetown Rd.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 14, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg, Md.				
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>				

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278-10-5872 Philip R. Schmeider Same as 12

No

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6-9-79

6-9-79

10401 Old Georgetown Rd.

6. Stuart Scott

Bladenburg, Md.

June 14, 1975 Ft. Lincoln

Burial

Robert A. Ramsey Funeral

Beltsville, Md.

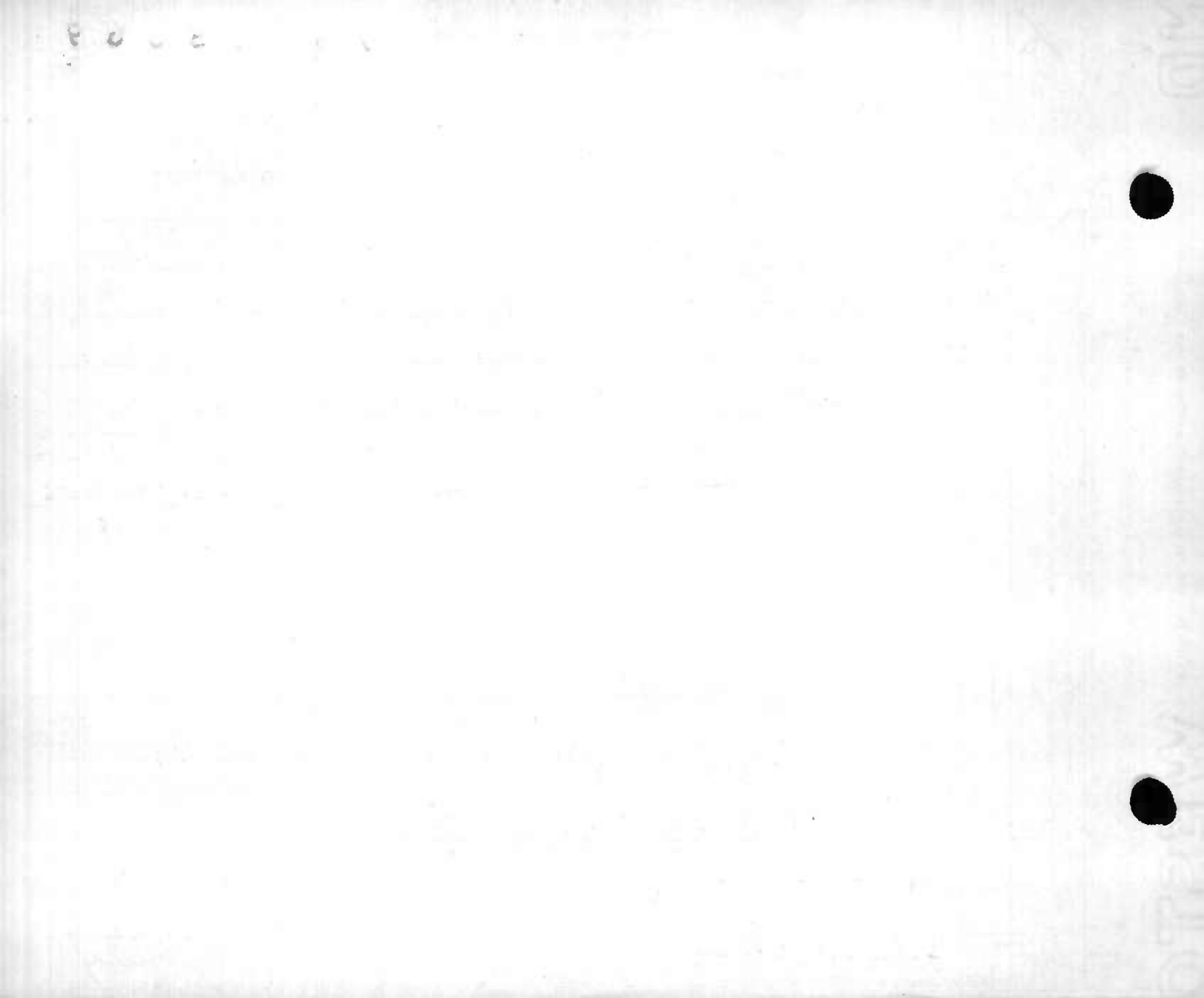
James, P.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 5 3 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Emmett Julian Scott				2a. DATE OF DEATH MONTH DAY YEAR June 29, 1979			
3. SEX Male				7b. HOUR 1:58 P.M.			
4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 79		7a. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2818 Spencer Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Orthodontist		12b. KIND OF BUSINESS OR INDUSTRY Dentistry	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2818 Spencer Road	
14. FATHER'S NAME FIRST MIDDLE LAST James E. Scott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Tolbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1918		16b. SOCIAL SECURITY NO. 577-54-0916A		17. INFORMANT ADDRESS Emma Scott, 2818 Spencer Road, Chevy Chase, Md.			
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 1629 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIOGENIC CARCINOMA AND 7 MOS DUE TO, OR AS A CONSEQUENCE OF (c) BIVENTRICULAR CARDIAC FAILURE 2 MOS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): NONE							
19a. DATE OF OPERATION MAR 16, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRADYCARDIA & PVC'S		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAR 13, 1979 to JUNE 29, 1979 , that (I) (we) lost saw the deceased alive on JUNE 26, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Hackney Jr. DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Hackney Jr.				22e. ADDRESS Howard Univ. Hosp., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 3, 1979		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Md.	
24. FUNERAL DIRECTOR NAME John F. Bolger ADDRESS McGuire Funeral Service, Inc., 7400 Ga. Ave NW				25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. REGISTRAR'S SIGNATURE Robert L. Hackney Jr.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First ROBERT		Middle F.	Last SEAGER		2a. DATE OF DEATH Month JUNE Day 10 Year 1979		2b. HOUR 445 P.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 19, 1911		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7608 Cayuga Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) C.P.A.		12b. KIND OF BUSINESS OR INDUSTRY Private Practice		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7608 Cayuga Ave.	
14. FATHER'S NAME First Frederick Middle A Last Seager		15. MOTHER'S MAIDEN NAME First Anna Middle Last Domres							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		(If yes give war or dates of service) WWII		16b. SOCIAL SECURITY NO. 134-10-7164		17. INFORMANT Address Harriet L. Seager, Wife. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: 4140 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 3 DAYS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE 15 YEARS DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HEPATOMA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 1965 , to JUNE 10, 1979 , that (I) (we) last saw the deceased alive on 6-10-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen W. DeJeter, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-10-1979			
22d. PHYSICIAN'S NAME (Type) STEPHEN W. DEJETER, M.D.		22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD. 20834							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/15/1979		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Altoona, Penna.			
24. FUNERAL DIRECTOR JOSEPH CAWLER'S SONS INC.				ADDRESS 6139 WISC. AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR JUN 15 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

OFFICE OF THE CHIEF OF BUREAU

WASHINGTON, D. C.

RECEIVED

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TO

FROM

SUBJECT

REMARKS

INITIALS

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15371	
1. DECEASED NAME (TYPE OR PRINT) Martin Raymond Secula										2a. DATE KNOWN OF DEATH ESTIMATED May 31 1979	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR May 29 1956	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 23 YRS.	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD May 31 1979	2d. HOUR 11:45 P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Tak Park Wash. Advent. Hosp.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sr. Master Sgt.		12b. KIND OF BUSINESS OR INDUSTRY Air Force			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3411 Stenford Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST John - Secula				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine - Turczyk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, WAR OR DATES) W.W. II		17. INFORMANT Stella Secula-Address Same as #13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Gold Rogers				TITLE (SPECIFY) M.D. Dep.				DATE SIGNED June 1 1979			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial				23b. DATE June 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington-Arlington Co.-Va.	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home - Riverdale, Maryland						25. DATE REC'D BY REGISTRAR (THE REGISTRAR'S SIGNATURE) JUN 11 1979					



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15372 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Joseph ALAN Seebold										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 6 14 19 79	
3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 6-29 60 6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 8. MARried <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.										2b. HOUR 12 M	
10. CITY OR TOWN OF DEATH Bethesda 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban DOA 12a. USUAL OCCUPATION (TYPE OF WORK) Student 12b. KIND OF BUSINESS OR INDUSTRY School										2c. DATE PRONOUNCED DEAD 6/14 19 79 2d. HOUR 12 M	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7201 Fairfax Road											
14. FATHER'S NAME FIRST MIDDLE LAST William A. Seebold 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Copperud											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 577 92 2764 17. INFORMANT ADDRESS William A. Seebold same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries. Severe. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Trauma Auto. Accident. DUE TO, OR AS A CONSEQUENCE OF (c) 8150										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 165m 6-14 19 79 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 165m 6-14 19 79 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Lost control of car hit utility pole.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bradly Blvd. Bethesda Montgomery Md											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED June 14, 1979											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. ADDRESS 7936 Old Georgetown Rd Beth. Md.											
23a. BURIAL, CREMATION, REMOVAL Burial 23b. DATE 6/16/79 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland											
24. FUNERAL DIRECTOR NAME ROBERT A. DUMPHREY FUNERAL HOMES, P.A. BETHESDA MARYLAND 25a. DATE RECEIVED BY REGISTRAR JUN 19 1979 25b. SIGNATURE Robert A. Dumphrey											

51000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15373			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST ETHEL SELTZER				JUNE 10 79 5 10 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 1894		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co. MD.	
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE NEW YORK 13c. COUNTY QUEENS 13d. CITY OR TOWN FAR ROCKAWAY				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13f. STREET ADDRESS 1261 CENTRAL AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST ISACAR DOV ROTH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 080-24-1080		17. INFORMANT ADDRESS 10845 CHILDS STREET MRS. SARAH BURNSTEIN SILVER SPRING, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE HEART FAILURE & SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PNEUMONIA, RT. LUNG.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 0744 6 19 79, to JUNE 10 1979, that (I) (we) last saw the deceased alive on JUNE 12 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE James Ronan MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES RONAN				22e. ADDRESS 7600 Carroll Avenue, Takoma Park, Maryland FAR ROCKAWAY, NEW YORK			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		23b. DATE JUNE 11, 1979		23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE MEMORIAL CHAPEL		23d. LOCATION CITY OR TOWN 250 CENTRAL AVENUE FAR ROCKAWAY, NEW YORK	
24. FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F.H.				25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]	
232 Carroll Street, N. W. Washington, D. C.							

01001

RECEIVED
JUL 1 1952



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[Faint text at the bottom of the page, including what appears to be a date 'JUL 1 1952' and other markings.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 15374		7 9					
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
Joseph		Shapiro		6-29-79		11 45		AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
male		WHITE		MONTH DAY YEAR		92 YRS.		MONTHS DAYS HOURS MIN	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
RUSSIA		U.S.A.				montgomery County		MD.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		PAPER HANGER		WALL PAPERING			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6121 MONTROSE ROAD	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT	
BENJAMIN		RACHEL		NO		059-12-3583		IRVING SHAPIRO, SON, ADDRESS 4926 ARCTIC TERRACE, ROCKVILLE, MARYLAND	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19 IMMEDIATE CAUSE (a)		20 DUE TO, OR AS A CONSEQUENCE OF (b)		21 DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140		Cardiac Arrest		atherosclerotic heart disease and congestive heart failure		4 days		IMMEDIATE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from 6/28 19 79 to 6/29 19 79, that (1) (we) last saw the deceased alive on 6/29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Robert L. Rosenberg		6-29-79		ROBERT L. ROSENBERG, MD.		6121 MONTROSE RD, ROCKVILLE, MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
BURIAL		7/1/1979		MOUNT LEBANON CEMETERY		ADELPHI PRINCE GEORGES MD.			
24 FUNERAL DIRECTOR		24b DATE REC'D. BY REGISTRAR		24c REGISTRAR'S SIGNATURE		24d NAME			
DONALD M. STEIN HEBREW MEMORIAL F. H.		JUL 5 1979		History		232 CARROLL STREET, N. W., WASHINGTON. D. C.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 3 7 5

REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Robert N. Shellenberg			2a. DATE OF DEATH MONTH DAY YEAR 6/10/79		2b. HOUR 3:51 A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 23 1915	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Italy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN GAITHERSBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MANFRED SHELLENBERG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SELMA MAYER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII 107-16-8666A	17. INFORMANT ADDRESS THELMA C. SHELLENBERG (SAME AS 13c)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 PERFORATED ULCER DUE TO, OR AS A CONSEQUENCE OF (b) Abused carrying Lug DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 240
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/9/79, 1979, to 6/10/79, 1979, that (I) (we) last saw the deceased alive on 6/9/79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E. D. G. A. R. H. LEVIAN		DEGREE M.D.		22c. DATE SIGNED 6/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIAN		22e. ADDRESS v 8630 FENTON ST., SILVER SPRING, MD. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6-11-79	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX VIRGINIA
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A		ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JUN 19 1979	25b. REGISTRAR'S SIGNATURE [Signature]

21001-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		7 9 1 5 3 7 6				REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Elizabeth		V.		Sheridan				6		11		79		9AM		M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS							
Female		White		Apr. 18, 1889		90		MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH											
Pa.		USA				Montgomery										MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Takoma Park		Washington Adventist		Hotel Maid													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		923 Cox St.									
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
James		Sheridan		Isabell												SLAVIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS											
no		071-09-3877		Mrs. Isabell Schiappa		#13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Bed rest + old age DUE TO, OR AS A CONSEQUENCE OF (c) Recent major surgery - Carcinoma of Colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 7 days B.R. 4 days																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
June 7, 1979		Carcinoma of colon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from June 4, 1979, to June 11, 1979, that (I) (we) lost the deceased alive on June 11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE W.W. Eastman		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-11-79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.W. Eastman		22e. ADDRESS 831 Univ. Blvd. East S.S. Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 15, 1979		23c. NAME OF CEMETERY OR FINAL RESTING PLACE St. Peter and Paul		23d. LOCATION CITY OR TOWN COUNTY STATE Elmira, N.Y.											
24 FUNERAL DIRECTOR NAME W.W. Taltavull		ADDRESS 4748 Wisc. Ave. N.W. Wash. D.C.		25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]											

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15377

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST		Male		White	
Martin Victor Sheridan		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR		02/16/1922		57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Florida		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		The Clinical Center, NIH		Contractor	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
13a. STATE COUNTY		NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		Route 2, Box 470	
Florida Brevard		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		Vinning Sheridan		FIRST MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
YES		11, Korea		The Medical Record	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
PART I. DEATH WAS CAUSED BY:		6/18/'79		Metastatic Carcinoma of Colon	
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiac Arrest		(b) Hepatic Failure		10 Minutes	
1539		DUE TO, OR AS A CONSEQUENCE OF		3 Months	
(c) Carcinoma of the colon		2 Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
HOUR A.M. MONTH DAY YEAR		P.M.		19	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that xxx (this hospital) attended the deceased from 12 June 1979, to 23 June 1979, that X (we) lost saw the deceased alive on 23 June 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. if we (did) not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thomas B. Smith M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thomas B. Smith M.D.		The Clinical Center, National Institutes of Health, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/27/79		Brevard Memorial	
23d. LOCATION		23e. DATE RECEIVED BY REGISTRAR		23f. SIGNATURE	
Cocoa, Florida		JUN 27 1979			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR	
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				JUN 27 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



1 5 0 1

11/15/55

TO: DIRECTOR, AIR FORCE
FROM: SAC, [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 5 3 7 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Georgia M. Showard					2a. DATE OF DEATH MONTH DAY YEAR 6 23 79			2b. HOUR 5:15P_M		
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 31 99		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNK Mears					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bettie Mapp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577 50 6320		17. INFORMANT ADDRESS Betty A. Baumgartner Same as item 13a-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 436- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) ✓ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from MAY 5 19 79 to 6/23 19 79 , that (1) we lost saw the deceased after on 6/15 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we interviewed the body after death.										
22b. SIGNATURE Thomas G. Ward DEGREE 3rd						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Ward						22e. ADDRESS 6116 Robinwood Rd. Bethesda, Md. 20034				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-27-79		23c. NAME OF CEMETERY OR CREMATORY Bellhaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bellhaven Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR JUN 28 1979				
1331 Rockville Pike Rockville, Md. 20852						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



OFFICE OF THE ATTORNEY GENERAL

Female	White	8	21	99	79	8 23 79 2:15P
Virginia	U.S.A.	X	XX	Montgomery	US Gov't.	
Rockville	Collingwood Nursing Home			Retired		
Maryland	Montgomery Germantown	X		13038 Hill House Court		
WM	Hearts	Bottle		Kapp		
No	- - -	577 50 6350	Betty A. Baumgartner	Same as then 13038		

Thomas A. Ward
6115 Robinwood Rd. Bethesda, Md.
Burial 6-29-79 Belhaven Cemetery Belhaven Virginia
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike Rockville, Md. 20852

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15379

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

John

Phillip

Shriver

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
6-9-79 1158 AM

3. SEX

Male

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR
6 5 1892

6. AGE (IN YEARS LAST BIRTHDAY)

87

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Takoma Park

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hosp.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Contractor

12b. KIND OF BUSINESS OR INDUSTRY

Retired

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Sil. Spr.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

527 Dale Drive

14. FATHER'S NAME

Unknown

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Unknown

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
578-07-2659

17. INFORMANT

ADDRESS
527 Dale Drive
Lucille M. Shriver Sil. Spr., Md.18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lung CA with metastasis

DUE TO, OR AS A CONSEQUENCE OF

(b)

COPD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from April 1979 to 6/9/79, that (I) (we) lost
saw the deceased alive on 6/9 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

6/9/79

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SMITH H. M.D.

22e. ADDRESS

8323 Haddon Dr. Takoma Park Md.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

6/11/79

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory Alexandria, Va.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME

Clark E. Warner

ADDRESS
8434 Ga. Ave.

25a. DATE REC'D. BY REGISTRAR

JUN 15 1979

25b. REGISTRAR'S SIGNATURE

Luttrell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91001



Mr. Montgomery, 211 S. 1st St.,
Montgomery, Ala. 36102
Dear Mr. Montgomery:

I am writing you to inform you that
the enclosed check for \$100.00 is
for the amount of the loan which
you have been granted. The check
is payable to the order of the
Federal Reserve Bank of Atlanta.
The check is dated 10/10/68.
The check is for the amount of
the loan which you have been
granted. The check is payable
to the order of the Federal
Reserve Bank of Atlanta. The
check is dated 10/10/68.

Sincerely,
Director, Federal Reserve Bank of Atlanta

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires: that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					9 1 5 3 8 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORRIS NMN SHRODER					2a. DATE OF DEATH MONTH DAY YEAR 06 30 79			2b. HOUR 9:45A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 10 18		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 407 DEERFIELD AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIR. OF HOUSING		12b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 407 DEERFIELD AVENUE		
14. FATHER'S NAME FIRST MIDDLE LAST MAX SHRODER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNY MILDWOFF				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2		17. INFORMANT ADDRESS Mrs. FLORENCE SHRODER SAME AS NO. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Cirrhosis - POSTNECROTIC 5715 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from October 19 78, to June 30 19 79, that (I) (we) last saw the deceased alive on JUNE 29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul M. Chang MD				22c. DATE SIGNED 06/30/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL P.L. CHANG	
22e. ADDRESS 2121 PENNSYLVANIA AVE N.W. WASHINGTON DC 20037									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/2/1979		23c. NAME OF CEMETERY OR CREMATORY ELM LAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE TONTAWANDA, NEW YORK			
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL F.H. 232 CARROLL STREET, N. W. WASHINGTON, D. C.					25a. DATE REC'D. BY REGISTRAR JUL 5 1979		25b. REGISTRAR SIGNATURE [Signature]		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Dr. E. Horace Siegler						2a. DATE OF DEATH MONTH DAY YEAR June 23 1979		2b. HOUR 12:10 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 29 1888		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 Tulip Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Entomologist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 201 Tulip Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Siegler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle C. Nanneau					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217 32 0679		17. INFORMANT ADDRESS Esther D. Siegler same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>21 (Feb)</u> , 19 <u>79</u> , to <u>6/23/79</u> , 19 <u> </u> , the (1) (we) lost saw the deceased alive on <u>6/21/79</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Deborah B. Goldberg				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEBORAH B. GOLDBERG				22e. ADDRESS 1106 SPRING ST, SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, PA BETHESDA MARYLAND				25a. DATE REC'D. BY REGISTRAR JUN 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Maria	MIDDLE NMN	LAST Sigmund	2a. DATE OF DEATH MONTH DAY YEAR 6 / 30 / 79		2b. HOUR 2:10 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? Canada		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5015 Battery Lane, #304		
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda				
14. FATHER'S NAME FIRST MIDDLE LAST Hynek Dokoupil				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Hostasek				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Jerry P. Sigmund, Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Collapse 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 5 days Years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 26, 19 79 , to June 30, 19 79 , that (I) (we) lost saw the deceased alive on June 30, 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joseph A. Romeo M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-1-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Romeo, M.D.				22e. ADDRESS 10401 Old Georgetown Rd. - Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-2-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland				25a. DATE RECORDED BY REGISTRAR JUL 9 1979		25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Jennie Silver			2a DATE OF DEATH MONTH DAY YEAR June 30 1979			2b HOUR 6:36 PM			
3 SEX Female		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR April 21 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Care Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Olney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 17908 Archwood Way	
14 FATHER'S NAME FIRST MIDDLE LAST Solomon Hurowitz				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Shapiro					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-74-5070		17 INFORMANT ADDRESS Md. Bernard Silver; 17908 Archwood Way, Olney					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause last } (b) Chronic arteriosclerotic Cardiovascular disease (c) disease } 10 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Lymphatic Leukemia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 3/26 1979 to 6/30 1979 , that (I) (we) lost saw the deceased alive on 6/30 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Gilbert E. Hurwitz, M.D.				DEGREE M.D.				22c DATE SIGNED 6/30/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Gilbert Hurwitz, M.D.				22e ADDRESS 1800 EYE ST. N.W. Wash. D.C. 20006					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7-3-79		23c NAME OF CEMETERY OR CREMATORY Nat'l. Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia			
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				ADDRESS Rockville, Md.		25a DATE REC'D. BY REGISTRAR JUL 3 1979		25b REGISTRAR'S SIGNATURE Heston McBrady	

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15384

1. DECEASED NAME (TYPE OR PRINT)			FIRST Gail			MIDDLE Sine			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH 6			DAY 6			YEAR 1979			2b. HOUR M														
3 SEX female			4 RACE White			5. DATE OF BIRTH (MONTH DAY YEAR) 7 29 39			6 AGE (IN YEARS LAST BIRTHDAY) 39 YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			2c. DATE PRONOUNCED DEAD			MONTH 6			DAY 6			YEAR 1979			2d. HOUR 2:50 P. M.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland						7b. CITIZEN OF WHAT COUNTRY? USA						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.																				
10. CITY OR TOWN OF DEATH Gaithersburg						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Montg. Co. School						12b. KIND OF BUSINESS OR INDUSTRY																				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE Maryland												13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 210 Brooks Ave					
14. FATHER'S NAME FIRST MIDDLE LAST Howard Stottmeyer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erma Sager																																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unknown						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-36-3011						17. INFORMANT ADDRESS Harry Stottmeyer MT. Airy Md.																										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound to face (.22 caliber)</u> DUE TO, OR AS A CONSEQUENCE OF 9650 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																						
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR <u>XX</u> MONTH DAY YEAR 4:45 P.M. 6 6 1979						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) shot by assailant																										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) park lot						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17400Blk Morningview Dr, Gaithersburg, Mont, MD																										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE Virginia L. Dolan M.D.						TITLE (SPECIFY) Assistant						MEDICAL EXAMINER						DATE SIGNED 6/7/79																				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street, Baltimore, MD 21201																																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6/9/79						23c. NAME OF CEMETERY OR CREMATORY Neelsville Presbyterian						23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Montg. Md.																				
24. FUNERAL DIRECTOR NAME W. C. Helk						ADDRESS Barnesville Md.						25a. DATE REC'D. BY REGISTRAR JUN 14 1979						25b. REGISTRAR'S SIGNATURE Henry McCurdy																				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15385			
1. DECEASED NAME (TYPE OR PRINT) Flora G. Skinner				2a. DATE OF DEATH MONTH 6 DAY 23 YEAR 79			
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH 5 DAY 14 YEAR 1922		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingwoods Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE FLORIDA		13b. COUNTY PALM BEACH		13c. CITY OR TOWN W. PALM BEACH		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Gustav MIDDLE Gelderman LAST Becker		15. MOTHER'S MAIDEN NAME FIRST Nettie MIDDLE Becker LAST Becker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 109-07-6181		17. INFORMANT Dorothy Katz ADDRESS 7505 Democracy Blvd. Bethesda Maryland 20034					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/5 19 79 to 6/23 19 79 , that (I) (we) last saw the deceased alive on 6/23 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. Hall DEGREE M.D.		22c. DATE SIGNED 6/23/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Hall	
22e. ADDRESS 1119 Rockville Pike Suite 502		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					
23b. DATE 6/24/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE Virginia		23e. DATE REC'D. BY REGISTRAR JUN 25 1979	
24. FUNERAL DIRECTOR NAME Francis I. Collins		24b. ADDRESS 500 Univ. Blvd. W. Spr. MD. 20901		24c. REGISTRAR'S SIGNATURE P. J. H. H. H.			

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Francis J. Collins, Sec. 10. 1901
1901. 10. 1901



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15386

1. DECEASED NAME (TYPE OR PRINT) CARROLL RAY SLONAKER				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-26 1979 11:25 AM			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR June 8 1927	6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD June 26, 1979	2d. HOUR 11:25 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Tot. Park Wash. Advent Hosp		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Agent		12b. KIND OF BUSINESS OR INDUSTRY Gen. Contract	
13a. STATE Md.				13b. CITY OR TOWN Princess George's Hyattsville		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Slonaker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Hesson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212 10 7292A		17. INFORMANT Ruth S. Kerns		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Dis. (c) Fracture Rt Hip							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days Yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION 5-22-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fract Rt Hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 5:20 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at Home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Northampton Ave Hyattsville Prince Georges Md			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE John R. Ragan		TITLE (SPECIFY) M.D. Dr. Ragan		MEDICAL EXAMINER		DATE SIGNED June 28 1979	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/29/79		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home				25a. DATE REC'D. BY REGISTRAR JUN 28 1979		25b. REGISTRAR'S SIGNATURE Anthony McBrady	

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1977

USA

John Thomas Alexander
117 111th Avenue
Sims

Three hundred and thirty
three hundred and thirty
three hundred and thirty



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 3 8 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
Anne						Smiles		6 7 79 10 ⁰⁰ P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		July 25 th , 1900		78		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH	
Penna.		U.S.A.				Rockville, Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		1810 McAuliffe Drive		Retired		Secy.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1810 McAuliffe Drive	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John Dixon					Ann				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
No					179 16 1744A		John J. Smiles (Same as 13E)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Carcinoma of Colon with metastases</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>April 19 79</i> to <i>6/7 19 79</i> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>5/25 19 79</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<i>W M Hall, M.D.</i>								6/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
William G. Hall MD			615 West Montgomery Ave. Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		6/8/79		Metropolitan Crem		Alexandria Virginia			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Rockville, Maryland			JUN 12 1979			<i>William G. Hall</i>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO. 9 15388										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Cecil M. Smith			6		2		79		5		55 ^{PM}		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS.			
M		W		6 23 1897		81 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park		Washington Adventist Hosp.		Unknown		Unknown							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Md.			P.G.		Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 347 Lloyd Station Rd.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Elmer H. Smith			Etta Dunbar										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
No			579-07-9244		Janice E. Kay		P.O. Box 347 Bowie, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>concealed by surgery</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION (STREET)			21g. CITY OR TOWN				
						3/29			29				
22a. I certify that (I) (this hospital) attended the deceased from 3/29 to 6/29 and that (I) (we) last saw the deceased alive on 6/29 and that it (my (our)) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			22c. DATE SIGNED							
Lewis H. Dennis, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
			831 Univ. Blvd. E. Silver Spring, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial			6-7-79		Ft. Lincoln Cemetery		Brentwood		P.G.		Md.		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR							
F. Gasch's Sons F.H. P.A. Hyattsville, Md.						JUN 11 1979							
						25b. REGISTRAR'S SIGNATURE							
						L. H. Dennis							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. 9		15389		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) EDITH S. SMITH				2a. DATE OF DEATH June 21, 1979				2b. HOUR 6:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 6, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vancouver, Wash.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9906 Julliard Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- G.P.O.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick -- Schroell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna -- Ugurhart					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Daughter Helen S. O'Brien, Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left lung</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 5</u> 19 <u>79</u> , to <u>6/21/79</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death.									
22b. SIGNATURE <u>Dr Joseph Kenrick</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>6/21/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr JOSEPH KENRICK</u>				22e. ADDRESS <u>6450 Wisconsin Ave, Chevy Chase, Md 20815</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/23/1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons				5130 Wisconsin Av. N.W. Washington, D.C.		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>	

98021



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 3 9 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELsie McCUBBIN SMITH		2a. DATE OF DEATH MONTH DAY YEAR 6-15-1979		2b. HOUR 10 ⁰⁰ P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 9, 1894	
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH TAKOMA PARK	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGO GARDENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. GOVERNMENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES JOHN McCUBBIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY EVA CARR		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. WW I 217-52-6039		17. INFORMANT KENNETH S. MILLER, JR. SAME AS 13 NEPHEW		18. ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4280 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C.C.F.</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypotension, Dehydration, C.V.A. & Residuals, Decubitus</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>2</u> 19 <u>79</u> to <u>6/15</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>5/21/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Cardinal</u>		22c. DATE SIGNED 6/16/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. C. VAID		22e. ADDRESS 7676 New Hampshire Ave	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901				25. DATE REC'D. BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McBrady</u>	



cleared by Dr. Lago/pc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15391

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MADGE		MIDDLE G.		LAST SMITH		2a. DATE OF DEATH MONTH DAY YEAR		6 25 79		2b. HOUR 8:25a M	
3. SEX female		4. RACE cauc		5. DATE OF BIRTH MONTH DAY YEAR		9 20 01		6. AGE (IN YEARS LAST BIRTHDAY) 78 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Accounting									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6707 Old Stage Road							
14. FATHER'S NAME FIRST MIDDLE LAST James Chaptman Greenshields		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Maude Pace													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT ADDRESS Barbara S. Gargano same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 } DUE TO, OR AS A CONSEQUENCE OF Cardio-Respiratory Arrest Intermittent Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) this hospital attended the deceased from April 26, 1979, to June 25, 1979, that (2) we last saw the deceased alive on June 20, 1979, and that in our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)															
22b. SIGNATURE Benjamin		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-25-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Aaron, M.D.		22e. ADDRESS 3720 Fannington Ave. New, Md 20795													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/28/79		23c. NAME OF CEMETERY OR CREMATORY Knollwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE East Cleveland, Ohio									
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR JUN 28 1979													
		25b. REGISTRAR'S SIGNATURE Anthony McCreedy													

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 5 3 9 2

REG. NO.

1. FOR - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Jonathan Sobeloff		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR Sept. 29, 1934		44 YRS		Montgomery County, MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
NEW YORK		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		Clinical Center, Bethesda, Md.		12b. KIND OF BUSINESS OR INDUSTRY LAW	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		MONTGOMERY		Bethesda	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
ISIDORE		EDITH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		377-32-5952		Mrs. Barbara Sobeloff, (Wife-NOK)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
PART I. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>ascites, pleural effusions</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>diffuse lymphoma, intermediate type</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) this hospital attended the deceased from June 22, 19 79, to June 22, 19 79, that (X) (we) lost saw the deceased alive on June 22, 19 79, and that in (24) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did not view the body after death.		22b. SIGNATURE Edward C Bradley		22c. DATE SIGNED 6-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. Edward C Bradley, MD		National Institutes Of Health Clinical Center, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		6/25/1979		KING DAVID MEMORIAL GARDEN FALLS CHURCH VIRGINIA	
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DONALD M. STEIN HEBREW MEMORIAL F.H. 232 CARROLL STREET, N.W., WASHINGTON, D.C.		JUN 26 1979		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 1 5 3 9 3		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Chu Har Soo Hoo</u>				2a DATE OF DEATH MONTH DAY YEAR <u>6/1/79</u>		2b HOUR <u>125 P.M.</u>			
3 SEX <u>female</u>		4 RACE <u>Oriental</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>June 26 1922</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>56</u> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>China</u>		7b CITIZEN OF WHAT COUNTRY? <u>China</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Hostess</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <u>10,101 Leder Road</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Wing Way Der</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>She Quong</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>219-46-7417</u>		17 INFORMANT <u>husband</u> ADDRESS <u>Kui H. Soo Hoo same as 13e</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute gastrointestinal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <u>Dr. (this hospital)</u> attended the deceased from <u>June 1</u> , 19 <u>79</u> , to <u>June 1</u> , 19 <u>79</u> , that <u>he</u> (we) last saw the deceased alive on <u>June 1</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Walter J. Kol</u> MD.				DEGREE <u>MD.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/1/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MILTON KOCH</u>				22e ADDRESS <u>10301 SILVER SPRING AVE. SILVER SPRING, MD 20902</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Jun. 4, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Mont. Md.</u>			
24 FUNERAL DIRECTOR NAME <u>Francis J. Collins</u>				24b ADDRESS <u>500 University Blvd., W. Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 5 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 5 3 9 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Benjamin		L		SOWELL				06		08	79	8:45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		Caucasian		MONTH DAY YEAR 04 12 07		72 YRS		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Argentina		U.S.A.				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		Foreign Service		State Dept.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11412 Nairn Rd.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Sidney M. Sowell		FIRST MIDDLE LAST Ermine S. Bagby											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		214-32-9685		Ruby Sowell, Wife		Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Aortic Aneurysm 6 mo's										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 6 yrs 6 mo's			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Diabetes Mellitus - Bronchitis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 8 June 19 79, that (I) (we) lost saw the deceased alive on 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death													
22b. SIGNATURE		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED							
M. L. White M.D.		M.D.				8 June 79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
M. L. WHITE, M.D.		9911 Georgia Ave Silver Spring, Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Removal		June 8, 1979		George Washington Medical School		Washington, D.C.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Capitol Funeral Service		Fairfax, Virginia		JUN 13 1979		Anthony Delaney							

W F C C I C V



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

5 3 9 5

1. DECEASED-NAME (Type or print)		First JUANITA	Middle SEARS	Lost SPILSBURY	20. DATE OF DEATH Month June Day 10 Year 1979		2b. HOUR 335 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-16-01		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3642 Gleneagle Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3642 Gleneagle Drive
14. FATHER'S NAME First Joseph Middle Anthony Last Spears		15. MOTHER'S MAIDEN NAME First Ada Middle Mary Last Pepit						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 577-03-4519		17. INFORMANT Address Security Bank, DC Augustus P. Crenshaw P.O. Box 1744, Amer.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 7-31, 1978 , to 6-4, 1979 , that (I) (we) last saw the deceased alive on 6-4, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Alberto Rotsztein		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-10-79		
22d. PHYSICIAN'S NAME (Type) Alberto Rotsztein		22e. ADDRESS 3701 Rossmore Blvd Silver Spring Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/13/1979		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia.		
24. FUNERAL DIRECTOR JOSEPH CAWLER & SONS INC. 5130 WISSE AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR DATE JUN 15 1979		25b. REGISTRAR'S SIGNATURE Henry McCreedy				

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[Faint, mostly illegible handwritten text, possibly a list or description of land parcels.]



[Handwritten signature or name.]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERTA LEE STEPHENS						2a. DATE OF DEATH MONTH DAY YEAR JUNE 17 79		2b. HOUR 0100A M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 10 04		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA						13b. COUNTY		13c. CITY OR TOWN ARLINGTON	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT E. LEE THOMAS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMILY FRANCIS THOMAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-46-3066		17. INFORMANT ADDRESS M. STEPHENS 4533 N. 32ND ST. ARLINGTON, VA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EXSANGUINATION SECONDARY TO RUPTURE OF LIVER TUMOR 2390 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 4 , 19 79 , to JUNE 17 , 19 79 , that (I) (we) lost saw the deceased alive on JUNE 17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Thomas P. Allen</i>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS P. ALLEN, M.D.				22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA			
24. FUNERAL DIRECTOR NAME IVES FUNERAL HOME				ADDRESS ARLINGTON, VA.		25a. DATE REC'D. BY REGISTRAR JUN 21 1979		25b. REGISTERED	

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 5 3 9 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JOHN BENJAMIN STERLING III						2a. DATE OF DEATH MONTH JUNE DAY 19 YEAR 1979		2b. HOUR 1:57AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH APRIL DAY 9 YEAR 1962		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.		7. IF UNDER 1 YEAR MONTHS 17 DAYS 17 HOURS 17 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DIST COLUMBIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10008 ROBERT RD SILVER SPRING				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE MARYLAND						13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST JOHN MIDDLE MARTIN LAST STERLING						15. MOTHER'S MAIDEN NAME FIRST ADDIE MIDDLE MARJORIE LAST TONER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216844161		17. INFORMANT JOHN M. STERLING (FATHER)		18. ADDRESS SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA 2040 DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NOV 10 1975 (3 YEARS, 7 MO)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): ANEMIA									
19a. DATE OF OPERATION 2 9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET — CITY OR TOWN — STATE —		22a. I certify that (1) (this hospital) attended the deceased from MARCH 19 1966 , to JUNE 19 79 , that (1) (we) last saw the deceased alive on JUNE 15 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE George R. Spence		DEGREE —				22c. DATE SIGNED 6/19/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE R. SPENCE MD.	
22e. ADDRESS 1515 HIGHLAND DRIVE SILVER SPRING		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/22/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JUN 25 1979		25b. REGISTRAR'S SIGNATURE Patricia Kelly		25c. REGISTRAR'S NAME —			

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EVERETT, WA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					7 9 1 5 3 9 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHEE ELIS STRUZYNIA					2a. DATE OF DEATH MONTH DAY YEAR June 3, 1979			2b. HOUR 10:45PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR APRIL 21, 1955		6 AGE (IN YEARS LAST BIRTHDAY) 24		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Africa		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Univ. of South Carolina	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN South Carolina Charleston					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1721 Ashley Hall Rd. #25		
14. FATHER'S NAME FIRST MIDDLE LAST George Struzyna					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Erika Schomburgk				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 155-38-4594		17 INFORMANT George Struzyna NOK			ADDRESS 203 Roscommon Place McMurray, Penna.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1719 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis and Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Synovial Cell Cancer									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 14, 1979 to June 3, 1979 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 3, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (I did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <i>Michael E. Trigg</i> MD					DEGREE MD			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Trigg M.D.					22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1979		23c. NAME OF CEMETERY OR CREMATORY Summerville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Summerville, South Carolina		25a. DATE FILED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 7 1979	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service					ADDRESS Fairfax, Va.				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15400 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN PICKHOLTZ SUTTIN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6 14 1979										2b. HOUR 2:06 PM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 8 96		6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 14 1979										2d. HOUR 2:06 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery										MD			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE PENNSYLVANIA				13b. COUNTY ALLEGHENY				13c. CITY OR TOWN PITTSBURGH				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5562 HOBART STREET											
14. FATHER'S NAME FIRST MIDDLE LAST MORITZ ROSENZWEIG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REGINA BAUER				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 161-44-7278				17. INFORMANT ADDRESS MRS. MARJORIE SPECTOR SILVER SPRING, MD. 2511 COLERIDGE ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic Cardio</u> DUE TO, OR AS A CONSEQUENCE OF Vas Dis. (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture Rt Hip</u>																									
19a. DATE OF OPERATION 4-23-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt. Hip										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR P.M. 4 20 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Tripped on step in home																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Coleridge Dr. Silver Spring, Md, Md																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																TITLE (SPECIFY)									
ACTUAL SIGNATURE J. E. J. Jones M.D. Dip																MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)																ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/17/1979				23c. NAME OF CEMETERY OR CREMATORY POALE ZEDECK CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE PITTSBURGH, ALLEGHENY, PA.													
24. FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.																25a. DATE RECEIVED BY REGISTRAR JUN 18 1979		25b. REGISTRAR'S SIGNATURE J. E. J. Jones							

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